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Long Term Care Strategic Plan

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Fairfax County

Dear Friends:

This report marks the conclusion of the Fairfax County Long Term Care Task Force strategic planning initiative. The Long Term Care Task Force was chartered by the Board of Supervisors and appointed by the County Executive to study long term care in Fairfax County and develop a strategic plan to meet the critical challenges that demographic changes will bring to our community. We began our work in late 1999 and we have spent the past 24 months learning about long term care, sharing the expertise that Task Force members brought to our work, and identifying key resource gaps. We reached out for individual citizens' input by conducting four community forums and asking what their long term care concerns were and how they should be addressed. We then considered the various assets offered by every sector of our community as we developed our goals, objectives and strategies. Lastly we held a Town Meeting to present our proposed recommendations and receive further public testimony. We then developed, reviewed, modified, and revised several versions of the report to ensure we captured the total picture and published a strategic plan that provided real value to the Board of Supervisors and our community.

Throughout this report you will see the results of the Task Force efforts. It is truly amazing to see what can be produced when interested individuals, organizations, business leaders, educators and faith-based representative's work together to develop innovative solutions to meet future community needs. I was also very impressed with the ongoing support of County staff and their dedication to this effort. They were called upon many times to assist with meetings and seek additional detail supporting our findings, adding more validity and richness to the Strategic Plan.

I am very proud of this report and our accomplishments, but our job is really just beginning. Strategic planning and preparing for the future must be an ongoing process. We must ensure that the recommendations put forth in this report go forward and continue to involve all sectors of the community. We should seek ongoing dialogue and support from our partners, and most importantly we must continue to strive for creativity and vision in developing new solutions.

It has been a pleasure serving as Chairman for the Long Term Care Task Force and I am thankful for the opportunity to have been a part of this very important work.

Sincerely,

Barry Ingram, Chairman
Fairfax County Long Term Care Task Force

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Forward

When the Task Force first embarked on this critical journey to develop a Strategic Plan for Long Term Care Services for our community, we knew that it was a worthwhile endeavor but we had no idea it would take over 24 months and several notebooks to complete the task. The process was demanding and even arduous at times but was designed to be comprehensive, broad-based and "leave no stone unturned"! The Strategic Plan identifies the critical goals, objectives and strategies needed to strengthen and improve our current system. It should serve as a roadmap for guiding the long term care system in the future. We are ready to move forward and begin to implement many of the strategies but we are also realistic. It will take time, resources and manpower. The Plan does not include specific details. It was deliberately designed to be flexible and encourage innovative and creative approaches to implementing the strategies. Success will depend on the continued support of the Board of Supervisors and an ongoing commitment from our Partners in long term care and the Fairfax Community.

Acknowledgements

The Citizens Task Force for Long Term Care was very fortunate in having the support and assistance of Fairfax County staff from various Human Service Agencies contributing to this project. Their ongoing support for the past two years has been an inspiration. Their names and respective agencies are listed on the next page.

We also wish to thank Rob Koreski and his staff for their invaluable contributions to the interim report. It involved many hours of research and data analysis and this work was very helpful in the development of the Strategic Plan.

A special acknowledgement is given to Kay Larmer, our Project Manager and her staff. Kay's tireless effort in keeping us on task was no easy assignment yet she did so with enthusiasm and commitment. Her dedication not only to this effort but to long term care in our community is greatly appreciated.

Thanks also to Tony Griffin, Verdia Haywood, JoAnne Jorgenson, Dana Paige, Jim Thur, Pat Franckewitz, Margo Kiely, Ken Garnes, and Paula Sampson who had the vision and foresight to see a critical need for a Strategic Plan for Long Term Care for our future and who remained committed and involved throughout this process.

Most importantly, we wish to thank the Board of Supervisors for their direction and support in this effort.

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FAIRFAX COUNTY LONG TERM CARE TASK FORCE

STRATEGIC PLAN

Executive Summary

Emerging Crisis

Fairfax County, Fairfax City and Falls Church City, hereafter referred to as Fairfax or Fairfax Community, have come together to address a number of trends and critical issues, which are seriously impacting the long term care system. Most urgently, the growth over the next decade of baby boomers, the over 85 age group and younger adults with disabilities will tax the system's infrastructure and capacity. In addition, there are many other issues such as the community's increasing cultural diversity, confusing and oftentimes inaccessible services, new advances in medical technologies and a general lack of long term care insurance coverage which have contributed to this emerging crisis.

In response to these challenges, the Fairfax County Board of Supervisors chartered The Long Term Care Task Force *to develop a Strategic Plan to meet the long term care needs of the Fairfax community.*

Task Force Process

The Task Force was comprised of 40 members representing a wide range of organizations involved in providing or using long term care services. In structuring the Task Force emphasis was placed on diversity and inclusiveness.

The Task Force defined long term care as "the sum of policies and programs that provide social, health, rehabilitative, and supportive services over an extended period of time to individuals eighteen and over who are limited in performing major life activities". It then determined that in order to address the community's emerging needs, the Strategic Plan should address the improvement and quality of services for the next ten years.

As a first step, Task Force members collectively considered several comprehensive analyses prepared by County staff. These analyses focused on issues such as demographic trends and factors affecting the need for long term care. The Task Force then established four criteria for assessing the need for quality long term care services. It determined that services should be available, accessible, acceptable, and affordable for all adult residents.

As a next step, the Task Force formed five small committees to identify gaps in currently available services. Collectively over 190 gaps were identified by these committees. In addition, four community forums were held to gather input from interested citizens. In

October 2000, an Interim Report was published which summarized the data analyses and the service gaps in the system in five separate areas: housing, transportation, supports to families, in-home services and community-based services. A copy of the committees' reports is included in Appendix A. The Task Force then developed a list of assets in our community, which could be utilized in developing the Strategic Plan. A copy of this list is found in Appendix B. The Task Force then prioritized the gaps and broke into ten "incubator" groups, which were charged with developing goals, objectives and strategies for the highest priority gaps.

Once the Incubator Groups' strategies were presented, it became apparent that they fell into four dominant themes; Increasing Public Awareness, Connecting People to Services, Promoting Independent, Supportive Living, and improving the Quality of the Long Term Care Workforce. A group was assigned to each of these themes and given responsibility for preparing a final set of relevant goals, objectives and strategies. These goals were adopted by the Task Force and received very positive support when presented to the community during a town meeting.

The Task Force also recognized a crosscutting issue; the need for a structure to oversee the implementation and maintenance of the recommended strategies. To this end, the Task Force urgently recommends that the Board of Supervisors establish a permanent Long Term Care Council. This body would be comprised of representatives of boards, authorities and commissions that have an interest in long term care as well as consumers and individuals from local advocacy and support organizations. It would guide and monitor the accomplishment of the recommendations of the Long Term Care Task Force. The Council would also be responsible for seeking funding sources and the development of new initiatives to take advantage of developments in the field of long term care to meet the changing needs of the population.

Recommendations

Theme One: ***Increasing Public Awareness***. Fairfax Residents must be knowledgeable about the trends, issues, and realities associated with long term care so that they may plan, decide and act on their own behalf.

- Develop and conduct a comprehensive and ongoing campaign that will result in long term Care issues becoming a part of the awareness and everyday knowledge of Fairfax residents.
- Initiate and maintain a process, which will be responsible for the creation and dissemination of information relevant to long term care for adults. The information should be presented in appropriate formats and languages through various distribution channels and will make use of all available media (print, TV, radio, internet, etc.).

Theme 2: ***Connecting People to Services***. Elderly persons, persons with disabilities and their caregivers must be connected to information and services that they need, when they need them, and at a level of intensity appropriate to their situation. The overall strategies for reaching this goal are to:

- Improve access to services by undertaking networking efforts, improving eligibility processes, and connecting people to services.

- Integrate the delivery of a range of services essential to address growing gaps in unmet service needs.
  - ✓ Create a one-stop eligibility determination process.
  - ✓ Form partnerships with provider organizations and educational institutions to address the growing gaps in available medical and ancillary services.
  - ✓ Develop similar relationships with faith community organizations that provide health related activities.
  - ✓ Improve access to public transportation services.
  - ✓ Increase the availability of low-cost dental care.

- Improve access to long term care services in Fairfax for persons of diverse cultures and/or with limited English proficiency.
  - ✓ Identify and adapt successful models in other multi-cultural communities for use in Fairfax County and build on current efforts within Fairfax.

- Enhance skills in the use of technology in order to access services.
  - ✓ Develop an educational strategy making use of the resources available in schools, libraries, businesses and not-for-profit organizations.

Theme 3: *Promoting Independent, Supportive Living*. Fairfax residents who are elderly or who have disabilities must be enabled to live as independently as possible. The overall strategy for reaching this goal is to increase the availability, affordability, and accessibility of supports that promote independence in the home and in the community. The Task Force developed twelve objectives in support of this strategy.

The objectives for this theme fall into four clusters: promoting independence in the community, promoting independence at home, promoting access in the community, and promoting quality environments for persons needing assistance with daily living.

Promoting Independence in the Community

- Increase and strengthen the availability, accessibility, and variety of community-based long term care options in response to the needs of people with disabilities.
- Increase the availability of support coordination, case management and consumer directed services as needed.
- Ensure adequate nutrition in the community by providing nutrition information, improving access to nutritional programs and increasing the total number of congregate meal sites.

Promoting Independence at Home

- Enhance, develop and coordinate supportive services in the home for persons with disabilities so they may have productive and fulfilling lives and maximize to the greatest extent possible home ownership.

- Make assistance available and affordable for persons with disabilities through advocacy by initiating or supporting legislation in the Virginia General Assembly.
- Modify homes to permit continued independence for residents.

Promoting Access to the Community
- Increase the supply of affordable, accessible housing.
- Develop an integrated transportation system that meets the needs of the elderly and adults with disabilities that is safe, acceptable, available, accessible, and affordable.
- Improve driving and pedestrian transport environments.
- Improve the quality of transportation services provided to elderly persons and persons with disabilities.

Promoting Quality Environments for People Needing Assistance with Daily Living
- Increase the quality and affordability of assisted living.
- Increase the quality and affordability of skilled nursing facilities.

Theme 4: *Improving and Expanding the Long Term Care Workforce*. The recruitment and retention of long term care providers must be increased and the quality of this workforce must be improved. An overall strategy and two objectives were developed in support of this goal.

- **Overall Strategy:** Develop a consortium for public and private providers of long term care services to share ideas and strategies for recruiting and retaining workers. The Consortium should be independent from the County and be a self-supporting public-private partnership that would have as its mission the improvement of the long term care workforce in Fairfax.

- Provide incentives that improve recruitment and increase retention in the long term care provider workforce.
  - ✓ Improve the compensation of nurses, paraprofessional health care workers and other direct service providers.
  - ✓ Increase the attractiveness of a career in the field of long term care.
  - ✓ Improve working conditions by establishing standards for accreditation of long term care organizations.
  - ✓ Provide transportation, which is a significant problem for many persons who are working in these organizations.

- Implement measures to improve the quality of the long term care workforce.
  - ✓ Promote health careers.
  - ✓ Provide increased training options.

Introduction

Fairfax is a suburban community of over one million residents, with a thriving and capable system of non-profit, private and public providers of long term care services. However, this community has come together to address a number of trends and critical issues affecting the ability of our system to effectively respond to residents' need for long term care and supportive services. Most urgently, the growth over the next decade of the baby boomers and the over 85 age group and younger adults with disabilities will tax the system's infrastructure and capacity to meet the need for services in a variety of areas. Also of importance, the increasing diversity in our community is already challenging providers' ability to offer language and culturally appropriate services. In addition, the system's breadth of resources is also one of its weaknesses, as the array of services can be overwhelming and difficult for families to navigate. And lastly trends that are affecting our nation are also greatly impacting Fairfax's long term care system. The general lack of long term care insurance coverage, new medical advances and technologies which are extending and sustaining life and the high percentage of women in the workforce who in the past were the primary caregivers have all contributed to this emerging crisis. In response to these challenges, the Fairfax County Board of Supervisors chartered the Long Term Care Task Force to identify strengths and areas for improvement and to develop a Strategic Plan to meet the needs of our community for the next ten years.

Background

The Board of Supervisors established the Long Term Care Task Force on March 22, 1999, when it endorsed a recommendation, which was developed by the Fairfax County Advisory Social Services Board and the Commission on Aging. These citizen boards recommended that a citizen study group be empowered to develop a strategic plan for long term care in Fairfax. In accepting this recommendation, the Board requested that a charter be developed for the Task Force. A working group consisting of representatives from the Advisory Social Services Board, the Commission on Aging, the Disabilities Services Board and the Health Care Advisory Board collaborated on developing a charter for the Task Force, which was endorsed by the Board of Supervisors on August 2, 1999.

Long Term Care Task Force Charter

The number of Fairfax residents who are unable to perform the essential activities of daily living is growing rapidly. Without adequate planning, existing agencies and institutions will be unprepared to effectively respond to residents' need for long term care. Those seeking help may fall into gaps of service delivery or endure needless duplication of administrative prerequisites. Major issues of service requirements, accessibility, affordability, eligibility, and quality must be addressed.

With the goal of improving the quality of long term care-related decisions, the major elements of the strategic plan should include:

A system for periodically assessing Fairfax residents' needs for long term care and how best to respond to them.

Methods for determining the range of specific long term care services utilized or desired by individuals, their families, and others as supporting caregivers. This includes developing care plans, marshalling required resources, arranging financing, and educating and training family members and other volunteer providers to furnish as much of the care as they can.

Identification of difficulties encountered in delivery of services and development of better practices and approaches to meeting long term care needs.

Finding ways to overcome barriers to accessing needed services including language and cultural issues, affordability, transportation requirements, housing arrangements, age based eligibility requirements, etc.

Establishment of principles that guide the role of local government, the private sector, and the community, and that support individuals and families in providing care.

Ensuring preventative and rehabilitative services to promote good physical, mental, and emotional health, including community education, health screening, and recreation.

Development and implementation of best practices and other care performance standards for the different groups of adults receiving long term care in institutional, home, and community based settings.

Development of specific recommendations for action on long term care issues.

A citizen study group supported by staff and other resources of private and public long term care constituencies will develop the strategic plan. The group will be comprised of approximately 30 representatives, including interested citizen groups, relevant County boards and commissions, long term care provider agencies, business, and academic interests. The group will work with identified expert resources. Throughout the process, periodic reports on status, interim findings and recommendations will be provided to the Board of Supervisors for consideration.

The working group identified approximately 40 organizations and interested groups to be represented on the Task Force. The working group also specified that the Task Force would address Fairfax County, Fairfax City and Falls Church City. One of the first tasks of the Task Force was the establishment of a nominating committee, which recommended nominees for the Chair and Vice Chair of the Task Force. The Task Force began meeting in November 1999, focusing on completing the necessary organizational and definitional work required to complete its assignment. Among these tasks were defining "long term care" and its mission for Fairfax residents as well as specifying the mission of the Task Force and the time frame to be addressed by the Strategic Plan.

Definition of Long Term Care

Long term care is the sum of policies and programs that provide social, health, rehabilitative, and supportive services over an extended period of time to those individuals who are limited in performing major life activities.

Mission of Long Term Care for Fairfax County, and Fairfax and Falls Church City Residents

The mission of Long Term Care is to provide community-based, individualized, and comprehensive services that promote consumer choice and independence for adults, eighteen and over, who require support services. These services should have the following attributes: availability, accessibility, acceptability, cost-effectiveness, continuity, and quality.

Task Force Mission

The Mission of the Long Term Care Task Force is to develop a Strategic Plan to develop and maintain long term care services described in the definition and mission of Long Term Care.

Time Frame

The Strategic Plan will address the improvement and quality of long term care-related decisions for the following ten years.

Work Process

The first few meetings of the Task Force were spent on learning about the demographic and socioeconomic trends in Fairfax as well as local, state, and national service delivery issues. Once this essential background had been established, the first major task undertaken by the Task Force was an identification of the gaps in Fairfax's continuum of long term care services. In order to carry out this task, the Task Force divided into five content area-specific committees: Housing; Transportation; Supports to Families; In-home Services and Community Based Services. In addition, a series of four Community Forums were held at various sites around the County to learn directly from the community where it believed there were gaps. The five committees collectively

identified a total of 190 service gaps. These gaps were then prioritized in a process that utilized the County's Group Decision Support Center.
At this point, in October 2000, the Phase One Report, "Report on Trends and Service Gaps" was published. This included a summary of the trends reported by staff and listed the service gaps uncovered by the five committees. A copy of the committee reports is included in Appendix A. The Task Force then developed a list of assets in the community that could be utilized in helping to developing solutions for the Strategic Plan. A copy of this list is found in Appendix B. It then regrouped for the purpose of identifying strategies to address the service gaps. For this task, the Task Force divided into ten "incubator groups," which were tasked with brainstorming solutions and researching best practices around a particular set of gaps. The ten incubator groups focused on: Developing the Long Term Care Workforce, Expanding Third Party Coverage, Improving Access to Transportation Services, Improving Mental Health, Mental Retardation and Substance Abuse Services, Overcoming Language and Cultural Barriers, Creating Housing Options, Improving Public Awareness and Education, Increasing Health Care Capacity, Maximizing Independence, and Strengthening Community Care.

The Incubator Groups reported back to the Task Force in May 2001. Approximately 70 different strategies were proposed to address the Service Gaps identified by the Task Force. These strategies were organized into four theme groups based on the approach recommended: Increasing Public Awareness, Connecting People to Services, Promoting Independent, Supportive Living, and Improving the Quality of the Long Term Care Workforce. At this point, the Task Force divided into four committees one last time to finalize the recommendations in each category and eliminate duplicate or contradictory strategies. The strategies were presented to the community in a Town Meeting on November 30, 2001. The Task Force officially endorsed the recommendations in December 2001 and made some minor additions at its final meeting in January 2002.

Putting Long Term Care into Perspective in Fairfax:
A Profile for 2000 and 2010

The Long Term Care Task Force has taken the time to look at the Fairfax area (Fairfax County, and the cities of Fairfax and Falls Church hereafter referred to as "Fairfax" or "Fairfax Community") in relation to the current and future long term care needs of its residents. In so doing, the Task Force has been able to see both how Fairfax differs from other jurisdictions and how it shares the challenges faced by others. The following section provides the reader with a profile**.**

Potential Population in Need of Long Term Care Services
The task force has identified persons 65 years and over, and adults under 65 with disabilities, as the primary population focus of its efforts. In 2000 there were an estimated 104,818 persons in this group, representing 10.4 percent of the Fairfax Community's population. In 2010, it is estimated that there will be 187,378 persons in this group, representing 16.8 percent of the Fairfax population, for a 78 percent increase over the 10-year period.

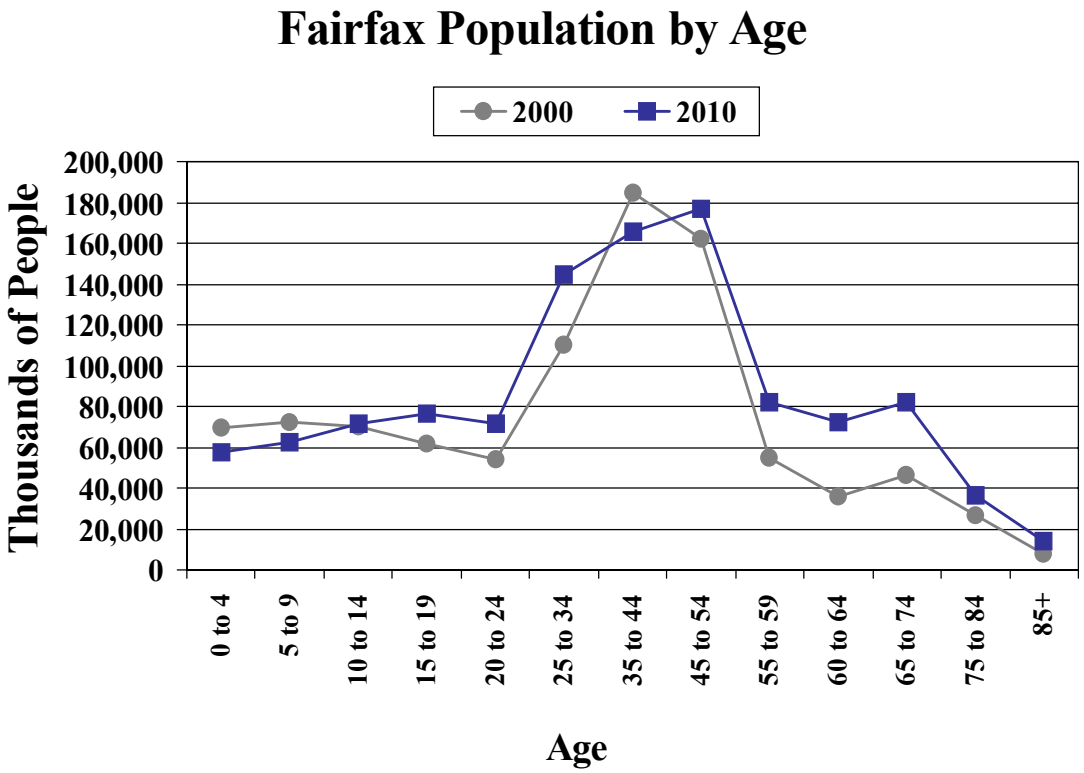
Growth of the Older Population
For the nation as a whole, older persons comprise the fastest growing segment of the population. While this is true of the Fairfax Community as well, older persons in the Community represent a smaller percentage of the population than that of the nation. In 2000, 12.4 percent of the nation's population is 65 or older, but only 8.1 percent of the Community's population is 65 or older.

When one looks at the next oldest age group, however, a different picture emerges. Nationally, persons in the 55-64 age group comprise 8.6 percent of the population. In Fairfax, they comprise 9.1 percent of the population.

Together, these facts tells us that, assuming current demographic trends hold, the Community's short-term challenges may be somewhat less daunting than elsewhere, but long term challenges may be more daunting. A close look at the Community's demographic shifts demonstrates how dramatically different the future may be.

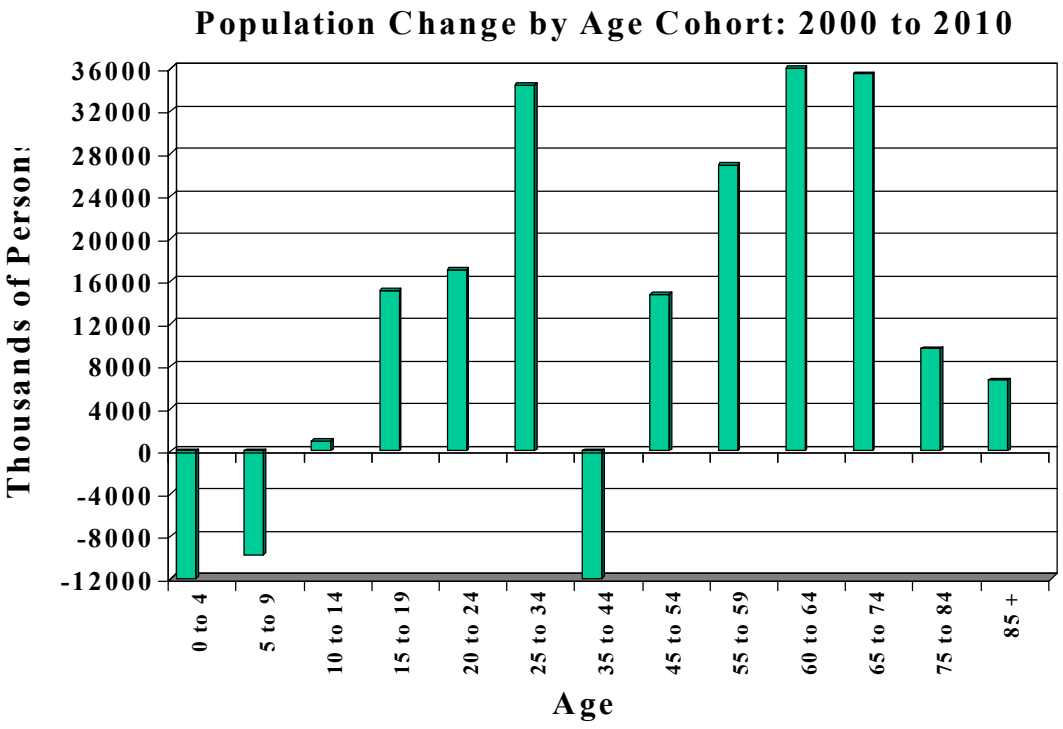
Chart 1 shows the population forecast estimates for the Community's age groups (cohorts) for 2000 and 2010. Chart 2 provides a closer look at the forecasted changes by age cohort. Chart 3 depicts those changes in terms of percentage increase or decrease.

Chart 1:



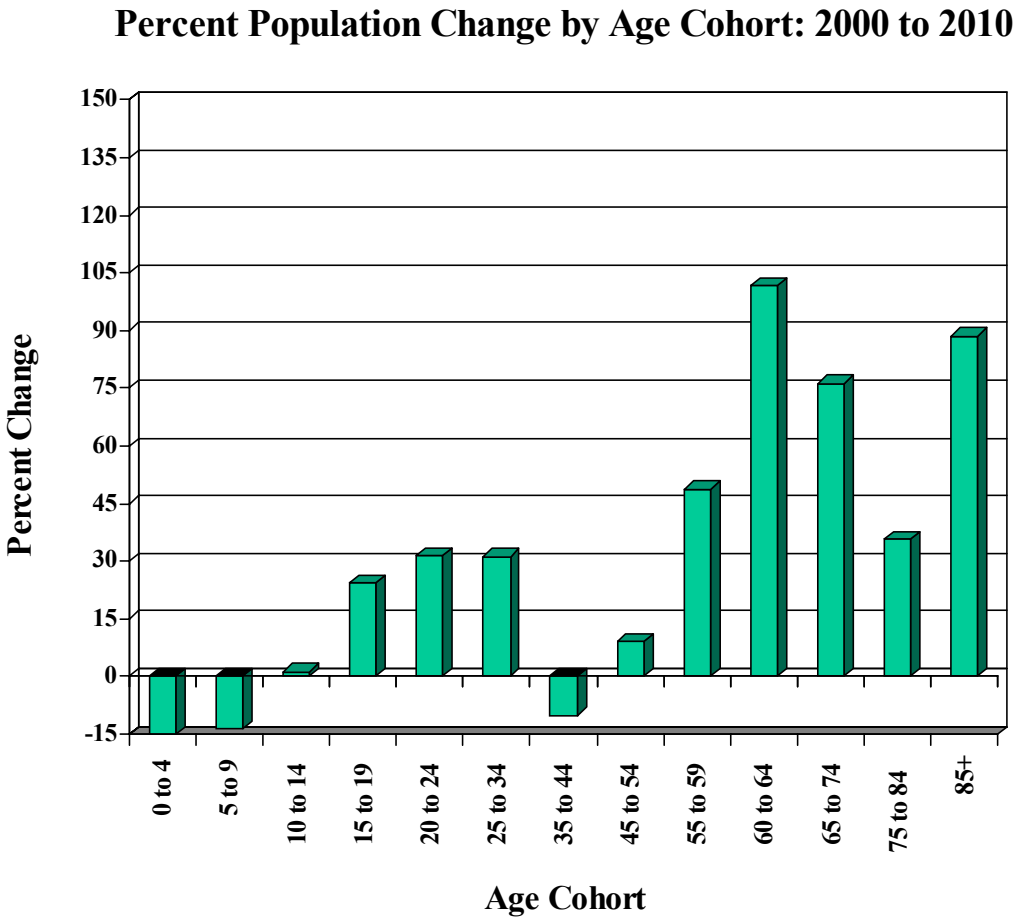
2000 Data from U.S. Census 2000; 2010 projections from Fairfax County Department of Human Services Systems Management

Chart 2:



2000 Data from U.S. Census 2000; 2010 projections from Fairfax County Department of Human Services Systems Management

Chart 3:



2000 Data from U.S. Census 2000; 2010 Projections from Fairfax County Department of Human Services Systems Management

Together, these charts tell us that the population from age 60 to age 74 is forecasted to grow the most in terms of total persons, while the population age 85 and over is forecasted to experience one of the largest percentage increase. Since the size of the elderly population is a primary indicator of the demand for long term care services these data are compelling. The greatest users of long term care services tend to be the oldest members of the population, those age 85 and over, so the growth in that age cohort is worthy of particular notice.

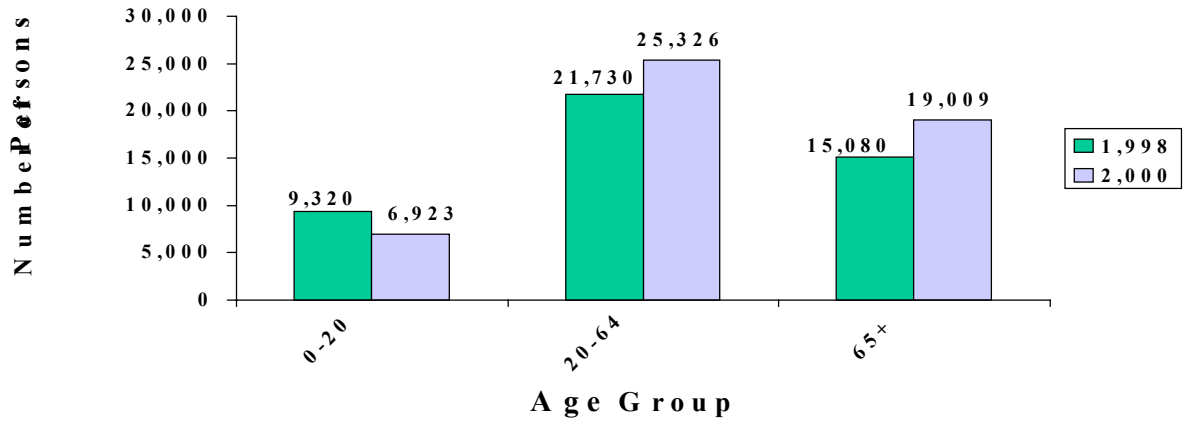
Change in the Adult Working Age Population

Also significant is the minimal growth, or decrease, in total numbers of persons in much of the working age population – persons age 35 to 54 – who are relied upon to be providers of long term care services. This points to a potential labor supply problem just at the time when it is most needed.

Persons with Disabilities

Nationally, statewide, and locally, age is the main factor affecting the likelihood of having a disability. In Fairfax in 2000, only 3.6 percent of the population 35-64 (21,730 persons) reported a disability, compared to 25.6 percent of the household population 65 and over (20,940 persons). However, in total numbers, the non-elderly population of persons with disabilities is larger than the elderly population with disabilities. Therefore, as the population ages, the total number of people with disabilities will increase.

Chart 4:



Sources: 1998 Household Survey, 2000 Community Assessment, Dept of Systems Management for HS

Overall, nearly 5.7 percent of the Fairfax Community's household population, or an estimated 56,472 persons, reported a disability in 2000. This rate is lower than rates quoted for the nation as a whole, although comparisons with national data often cannot reliably be made due to differing definitions of disability.

Although the likelihood of having a disability increases with age, a significant national trend is that the prevalence of disability among the elderly declined by 3.6 percent from 1984 to1994. This suggests that elderly persons as a group may be healthier than they were in prior years.

The Need for Assistance with the Activities of Daily Living
Although there are over 100,000 persons in Fairfax who are elderly or have a disability, many elderly persons and many persons with disabilities never require long term care assistance. Therefore, another view of the population is needed.

Activities of daily living (ADL's) are the basic activities one must perform to care for oneself, such as bathing, eating, dressing, using the toilet, and walking. The size of the population needing assistance with ADL's is a better measure of the population needing long term care services. As Table 1 demonstrates, the estimated number of persons needing such assistance was 14,500 in 1995 and will grow to an estimated 24,280 in 2010.

Table 1:

Estimates of Number of Persons Needing Assistance with
Activities of Daily Living (ADL's)

Age Cohort	Percentage of Age Cohort – 1995 Baseline	Persons Needing Assistance with ADL's – 1995	Persons Needing Assistance 2000 (1998 estimate)	Persons Needing Assistance 2005 (1999 estimate)	Persons Needing Assistance 2010 (1999 estimate)
18 – 34	.9%	2,000	1,840	1,920	2,080
35 – 54	1.1%	3,500	3,660	3,820	3,770
55 – 64	3.1%	2,100	3,100	3,960	4,780
65+	10.3%	6,900	8,750	10,700	13,650
Totals		14,500	17,350	20,400	24,280
Population 18+		673,284	721,383	792,972	860,661
Total Population		879,400	966,137	1,045,417	1,112,943

Baseline data from *Fairfax-Falls Church Community Needs Assessment – 1995*

In 1995, 47 percent of the persons needing assistance with ADL's were over 65 years of age. Based on the 1999 population forecasts, this percentage will rise to 50 percent in 2000 and 56 percent by 2010.

The trend toward needing increased assistance with advancing age is supported by data from the 1990 U.S. Census, which revealed that nearly 18 percent of Virginians age 60 and over had either mobility or self-care limitations (or both), but 55 percent of the population age 85 and over had these limitations.

Income and Age
The median household income of the Fairfax Community's older population is three times that of the nation's older population.

- The 2000 median household income in Fairfax for persons aged 65 and over was $60,000, which represented 73 percent of the median income for all households.

- Nationally, the median household income for older persons was $20,761, representing 54 percent of the nation's median household income.

Within this picture of relative prosperity, however, there are low-income persons with significant needs. Approximately 8 percent, or 6,500 persons age 65 and over in the Community, receive Medicaid assistance.

For the elderly, income data alone can be unreliable as a measure of financial distress or economic need. Many elderly may experience a reduction in real income as they age, but they may have other assets or personal wealth that ensures they are not in financial distress.
It should also be noted that there is not adequate data available to forecast future income levels for the elderly population in Fairfax. The high median income for working households may mean higher retirement incomes for "baby boomers" who are now approaching the last few years of their working lives, but data are currently not available to substantiate this conclusion. ***The future pattern of out-migration for this generation as they retire is also a major unknown, which could significantly affect future income distribution within age groups, as well as limit the ability to forecast numbers of people for age groupings over 65.***

Income and Disability
In the Fairfax Community, persons with disabilities are disproportionately represented among low-income persons (See Table 2). While disability rates increase with age in all income groups, it is lower in all age groups for households with incomes over $41,000.

Table 2:

Population Percentages by Disability Status and Age
Within Income Group

Disability Status	0 – 17	18 – 34	35 – 54	55 – 64	65 & up
Households with Incomes below $41,000 (below 50% of 2000 County median income)					
With Long Lasting Condition	4%	7%	11%	19%	33%
No Long Lasting Condition	96%	93%	89%	81%	67%
Households with Incomes of $41,000 - $81,999 (50% to 100% of 2000 County median income)					
With Long Lasting Condition	2%	3%	5%	9%	25%
No Long Lasting Condition	98%	97%	95%	91%	75%
Households with Incomes of $82,000 and above (100% of 2000 County median income and above)					
With Long Lasting Condition	2%	3%	3%	4%	23%
No Long Lasting Condition	98%	97%	97%	96%	77%

Based on data from the *2000 Fairfax Falls Church Community Assessment*

- 33 percent of persons aged 65 and over who live in households with incomes of $41,000 or less have disabilities, compared to less than 25% with disabilities for persons aged 65 and over who live in households with incomes over $41,000.

- For all persons under 65, the percentage of persons who live in households with income of $41,000 or less and have disabilities is two to four times the percentage of persons in higher income groups in this age range who have disabilities.

- In addition, the 2000 Household Survey revealed that 21 percent of Fairfax residents with disabilities, age 21-60, are not in the labor force, compared to only 10 percent of residents without disabilities.

Mobility Issues

The need for assistance increases with the loss of mobility and access to transportation, especially automobiles. Nationally, according to the Administration on Aging, the population of disabled persons who do not drive (25 to 30 million) is significantly larger than the population of elderly who do not drive (8 million). Since these numbers are likely to grow, meeting the mobility needs of these persons is likely to present a major challenge.

The percentage of elderly without access to a vehicle in Fairfax is far less than the national rate. Based on the 1998 Household Survey data, less than 0.5 percent of persons age 60 and over do not have access to a vehicle, compared to over 19 percent of elderly nationally. These figures do not indicate whether or not a member of the household can actually drive, but only that a vehicle is available to the household.

The larger mobility issue is one of safety, particularly for a community such as Fairfax which is built around the use of the automobile as the primary mode of travel and an essential means to access almost any element of community life. There is a common perception of older driver safety problems, but a 2000 report from the federal Department of Transportation (DOT) indicated that the fatality rate remained reasonably level up to age 75, then begins to rise, climbing steeply for persons over 80.

Equally, if not more pertinent, is the issue of pedestrian safety. The DOT report also states that “pedestrians aged 70 and over represented over 9 percent of the population, but accounted for 17 percent of all pedestrian fatalities in 2000”.

The need for transportation assistance may be greater for younger persons with disabilities than for the elderly, constituting a significant barrier to employment and higher income. The 1998 Household Survey reported that 16 percent of persons with physical or sensory disabilities use public transportation to go to work, compared to only 9 percent of persons without these disabilities. The availability of transportation may be a factor in the lower labor force participation rates among persons with disabilities noted above.

Living Arrangements
Living arrangements, particularly in the case of older persons living alone, are an indicator of the potential need for assistance. According to an analysis of 2000 Census data by the Administration on Aging:

- Over half (55%) the older noninstitutionalized persons lived with their spouse in 2000. Approximately 10.1 million or 73% of older men, and 7.7 million or 41% of older women, lived with their spouse (Figure 3). The proportion living with their spouse decreased with age, especially for women. Only 28.8% of women 75+ years old lived with a spouse.

- About 30% (9.7 million) of all noninstitutionalized older persons in 2000 lived alone (7.4 million women, 2.4 million men). They represented 40% of older women and 17% of older men. The proportion living alone increases with advanced age. Among women aged 75 and over, for example, half (49.4%) lived alone.

- About 633,000 grandparents aged 65 or over maintained households in which grandchildren were present in 1997. In addition, 510,000 grandparents over 65 years lived in parent- maintained households in which their grandchildren were present.

- While a relatively small number (1.56 million) and percentage (4.5%) of the 65+ population lived in nursing homes in 2000, the percentage increases dramatically with age, ranging from 1.1% for persons 65-74 years to 4.7% for persons 75-84 years and 18.2% for persons 85+.

Family Caregiver Issues
Nearly one in four U.S. households provides care to a relative or friend age 50 or older. Nationally, relatives are estimated to provide 85 percent of the care for persons needing long term care assistance. The importance of family supports for persons needing long term care must not be overlooked. The National Academy on an Aging Society has reported that “50 percent of the persons with long term care needs and no family network are in institutions.” But, in contrast, only “7 percent of the persons with long term care needs and access to family caregivers are in institutions.” The ramifications of these two statements are profound, both for the recipients of assistance and for the family caregivers.

The American Society on Aging (ASA) reports that nearly three-fourths (72 percent) of caregivers are female, and the average caregiver is 57 years old, with more than one-third age 65 and over. The ASA estimates that nearly three-fourths of caregivers live with the care recipient, and 20-40 percent are in the “sandwich generation,” caring for children under 18 in addition to a disabled older relative.
In the Fairfax Community, there are several trends that affect the availability of family members as caregivers.

- The high percentage of women in the labor force in Fairfax (over 72 percent in 2000, compared to 59 percent nationally) constrains the availability of women as possible caregivers for family members. This situation may also add to the unmet demand for paid caregivers in the community.

- The overall high labor force participation rate in Fairfax, nearly 79 percent compared to 66 percent nationally, also contributes to the labor supply shortage for home and personal care providers.

- The continued trend toward smaller household size in Fairfax means that there are likely to be fewer family caregivers in the future. Household size in Fairfax has decreased from 2.75 in 1990 to 2.73 in 2000 to an estimated 2.68 in 2010.

The Paid Caregiver Work Force

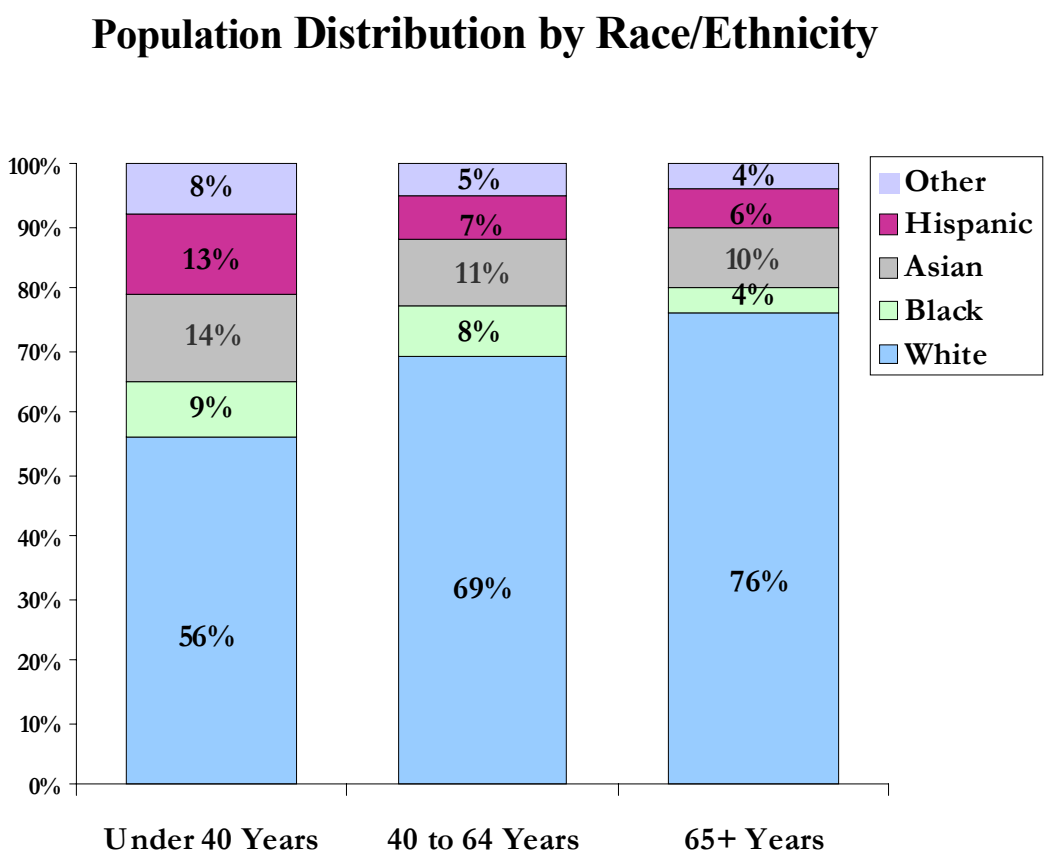
The development of in-home medical technologies, substantial cost savings, and patients' preference for care in the home have helped make this once small segment of the workforce one of the fastest growing in the U.S. economy. The number of elderly persons is projected to rise substantially. In Fairfax, the elderly in 2000 account for 50% of persons needing ADL assistance, and by 2010, the percentage of elderly will increase to 56% due to faster growth in numbers of elderly overall and a higher rate of need with increasing age.

According to a 1998 report from the Bureau of Labor and Statistics, projected rates of employment growth for this industry range from 8% in hospitals, the largest and slowest growing industry segment, to 80% in the much smaller home health care segment. Health service occupations such as nursing and psychiatric aides, medical assistants, home health aides, and personal care attendants for younger disabled persons attract many workers with little or no specialized education or training. In fact, 56% of the workers in nursing and personal care facilities have a high school diploma or less, as do 24% of the workers in hospitals. In Virginia, 75 hours of training for certification of home health care providers is suggested but not required.

The median hourly wage of home health care providers is $8.71 per hour – working an average of 29.6 hours a week. Total annual earnings around $13,000, with monthly incomes around $1,030, no health benefits or reimbursement for travel to and from appointments, result in extremely high turnover for workers in this field. Given the average monthly rent of $1,129 for housing in Fairfax, the probability of an individual choosing home health care as their primary field of work is slim. Home health care occupations have one of the highest turnover rates due to low pay and status, poor benefits, low training requirements and high emotional demands of the work. Most home health aides work part-time on an on-call basis, have a second job, or live in a household where their income is supplemented by other members of that household.

Racial and Ethnic Diversity
As Chart 5 shows, the Fairfax Community's older population is less diverse than those under 65 years of age, although it is likely that the older population will become more diverse over time if current population trends remain. Nationwide, minority populations are expected to comprise 25 percent of the elderly population in 2030. In Fairfax, that percentage is likely to be reached earlier.

Chart 5:



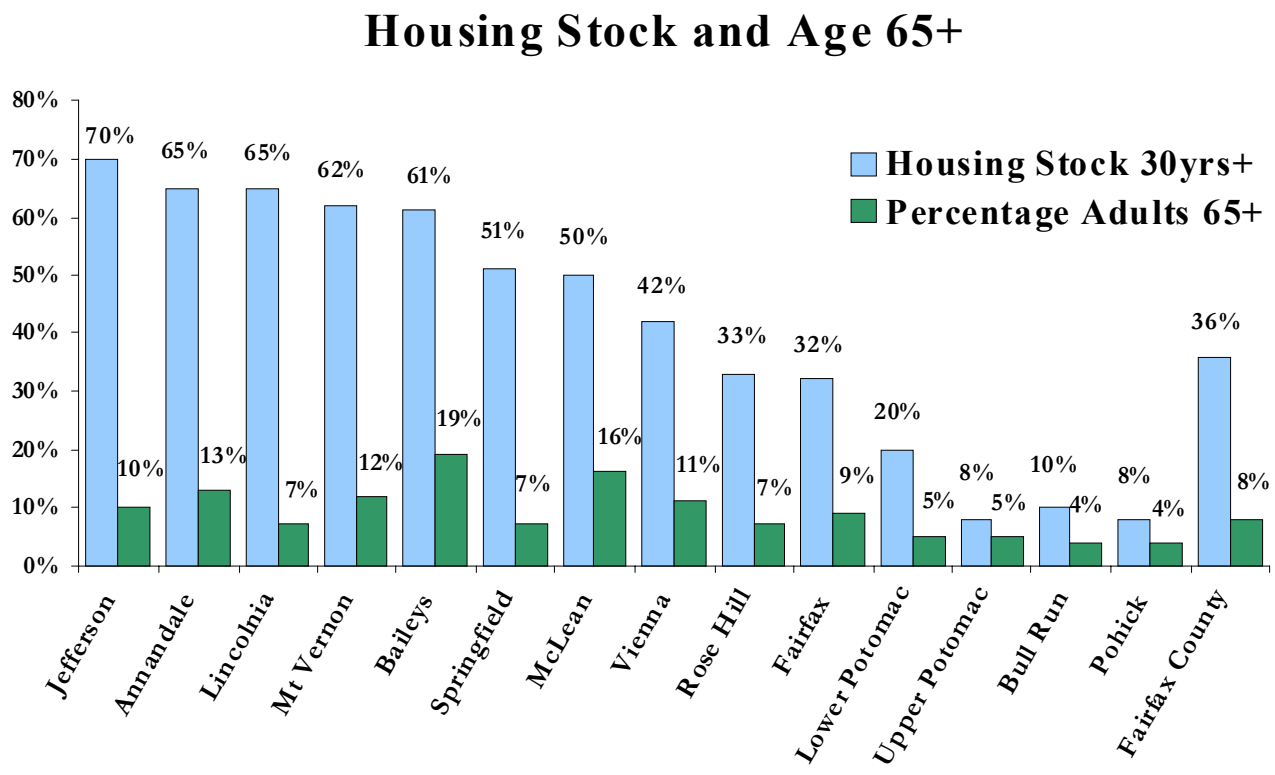
Source: Fairfax-Falls Church Community Assessment

Language and Cultural Diversity
Fairfax is rapidly becoming more linguistically diverse as the percentage of persons speaking a language other than English at home has risen from 11 percent in 1980 to 19 percent in 1990 to 35 percent in 2000. While many of these persons speak English at home as well, the data presents challenges from the perspective of both service providers and service recipients.

Population and the Age of Housing Stock

For the Fairfax Community as a whole, 36 percent of the housing stock is 30 years old or more but in some areas, primarily those inside the Beltway, the percentages are much higher. Several of these areas are also among the highest in Fairfax in the percentage of residents 65 and over. (See Chart 6) Challenges in home maintenance, home repair, and home modification for persons "aging in place" are likely to arise if current trends remain.

Chart 6:



Service Demand Projections for 2010

As a way of thinking about the magnitude of future long term care needs, and the scope of the strategies required to address them, it is useful to make estimates of future service utilization and demand based upon current utilization and demand and projected population growth. These estimates assume, for planning purposes only, that current trends in population, disability rates, and other socioeconomic factors, as well as regulatory programmatic conditions, all remain the same. In reality, changes are likely to occur within the next 10 years that would affect the estimates provided in this section.

1. Adult Day Health Care

Currently there are 110 adult day health care clients served each day with a waiting list of 96 persons. The primary age group served is persons 75 and over. To meet 2010 projections, there would be 178 clients served each day and a waiting list of 156 persons.

2. Senior Centers

Currently there are 5,833 seniors enrolled at the County's senior centers, and they made approximately 188,212 visits to the centers in FY 2001. In 2010, there would be a needed capacity for 11,700 enrolled seniors making 347,000 visits.

3. Transportation Service by FASTRAN

One-way rides provided by FASTRAN in FY 2001 totaled over 542,000 for elderly and disabled riders, a 9.6% increase over FY 2000. In 2010, it would take over 890,000 rides to provide an equivalent level of service.

4. Home Delivered Meals

In 2001, 237,657 meals were delivered to 1,323 persons. In 2010, 390,200 meals would be delivered to 1,900 persons.

5. Housing Authority's Waiting List

In 1999, there were 548 elderly persons and 1,219 persons with disabilities on the Fairfax County Housing Authority's waiting list for assisted housing. By 2010, growth in these segments of the population could increase these numbers to 787 elderly and 1,476 persons with disabilities.

6. Residential Mental Health Services

Currently, there are 560 persons awaiting admission to one of the four mental health group homes in the County. Projections for 2010 are not meaningful, since those who apply now do not have a chance of being admitted in their lifetime. The new 36-bed facility, Stevenson Place, already has a waiting list of 70 persons.

7. Group Homes for Persons with Mental Retardation, Concern over Caregivers

Based on 2001 survey data, there are 631 persons awaiting placement in a residential setting. Without more specific demographic information regarding the number and age distribution of persons with mental retardation, projections about 2010 demand cannot be made. However, there is concern over the age of the caregivers for the persons on the waiting list. Twelve percent are 70 or over; 16 percent are age 60-69; 39 percent are age 50-59. Currently, 37% of the individuals on the waiting list is considered to be in a "high-risk" situation; that is, the family feels they cannot continue with their current care arrangement. In ten years, as the current group of caregivers ages, the number of persons in high-risk situations is likely to increase.

8. Home Repair for the Elderly and Disabled

Approximately 80 homes are repaired each year by the Housing Authority's home repair program for the elderly and disabled, with a waiting list of 40 homes. Currently, 36 percent of the Community's housing stock is 30 years old or older, and nearly 9 percent of the population is 65 or over. In 2010, 59 percent of the housing stock will be 30 years old or older, and nearly 12 percent of the population will be 65 or over. It is difficult to predict what service requirements these two trends may combine to create.

9. Assisted Living Beds

In 2001, there were 3,209 assisted living beds in Fairfax. Assuming that persons age 75 and over are those most likely to live in assisted living facilities, the equivalent number of beds needed in 2010 would be 4,200. The current population of younger adults with more severe disabilities could well impact on that number beyond the year 2010.

10. Affordable Assisted Living Beds

A 2000 study commissioned by the Fairfax County Housing and Redevelopment Authority found no affordable assisted living beds in Fairfax and a current annual demand for 610 beds from residents and 406 from outside the Community for a total of 1,016 affordable assisted living beds. In 2010, assuming no changes in the percentage of low-income elderly, the annual demand would be 1,645.

11. Congregate Housing

There are currently 2,768 congregate housing units in Fairfax. In 2010, there would be a need for about 4,500.

12. Nursing Beds

There are currently 1,988 nursing home beds in Fairfax, and there is a state moratorium on the construction of new beds. Using 1995 national utilization rates per thousand for the age groups 65-74 (10 per thousand), 75-85 (46 per thousand), and 85 and over (199 per thousand), the number of beds needed in 2010 would be approximately 4,860. Using the 1998 Northern Virginia utilization rate for persons age 65 and over (27.9 per thousand), the number of beds in 2010 would be 3,710. The latter figure may be low due to the large increase in the group most likely to use nursing beds, persons age 85 and over, between 1998 and 2010.

13. Case Management

Currently, there are twenty-nine staff-year-equivalent positions providing case management services through the Fairfax County Department of Family Services, Adult Services and the Care Network for Seniors, with an average caseload of 45 each. To maintain this caseload ratio, there would need to be 35 staff-year-equivalent positions to provide case management to approximately 1,600 cases by the year 2010.

Recommendations

The Task Force is recommending twenty-one objectives and approximately ninety strategies for improving the system of long term care services in Fairfax. The strategies are organized into four theme areas: Increasing Public Awareness, Connecting People to Services, Promoting Independent, Supportive Living and Improving and Expanding a Qualified Long Term Care Workforce. In addition to the four theme areas, the Task Force felt it was important to recommend a structure for ensuring the accomplishment of the objectives it recommended. Therefore, an Overall Strategy was developed which, if executed, will ensure that the Task Force Recommendations are implemented.

Overall Strategy

The Long Term Care Task Force recommends the establishment of a Long Term Care Council. The Council would provide oversight and leadership to the coordinated and collaborative efforts needed to implement the Task Force's recommended strategies for improving long term care and supportive services in Fairfax County, while ensuring ongoing assessment of needs for long term care in our community.

This Long Term Care Council would include representatives from each of the boards, authorities, and commissions that currently work on long term care issues as part of their overall responsibilities as well as consumers and representatives from local advocacy and support organizations. It would be endorsed by the Board of Supervisors and be supported by County staff.

The Long Term Care Council would meet at least quarterly and would be charged with:

- Developing a work plan in cooperation with County staff for action steps needed to implement the recommended strategies of the Long Term Care Task Force.
- Improving the collaboration and coordination among County staff and the various boards, commissions, etc., to ensure that they work together to improve long term care.
- Overseeing the implementation of the recommendations of the Long Term Care Task Force and reporting to the community and the Board of Supervisors the progress being made.
- Developing new initiatives and updating the recommendations, as appropriate.
- Working with the private provider community to accomplish these objectives and seeking resources, grants and other non-County funding as appropriate.
- Exploring the feasibility of developing an independent public/private partnership that would collaborate on long term care issues, and oversee the implementation of some of the Task Force recommendations, particularly strategies related to development of the long term care work force.
- Establishing guiding principles for the role of local government, the private sector and the community in the provision of long term care services.

Theme #1: Increasing Public Awareness About Long Term Care Issues

Demographic trends suggest that most residents of Fairfax will be facing long term care issues for themselves, their relatives, or their friends some time during the next decade. The extent to which they are aware and equipped to deal with these issues will have a great bearing on the Fairfax Community's ability to avoid a crisis of care. As in many sectors of the economy, well-informed and proactive consumers are a powerful force for ensuring the availability, accessibility, and affordability of long term care services. The need for improving consumer awareness, knowledge, and access to information was identified as an important theme by all of the committees of the Task Force in its Phase One Report of October 2000.

GOAL: FAIRFAX RESIDENTS WILL BE AWARE OF THE TRENDS, ISSUES, AND REALITIES ASSOCIATED WITH LONG TERM CARE SO THAT THEY MAY PLAN, DECIDE AND ACT ON THEIR OWN BEHALF.

Overall Strategy: The Task Force believes that long term care concerns are community-wide, and as such, the best way to address the concerns is through an approach that is broadly representative and inclusive of the community. The Task Force recommends that both the "Public Awareness" theme and the "Connecting People to Services" theme that follows should be the primary responsibility of an entity that the Task Force, for the purposes of best describing its intent, calls "1-800 HELP-4-ME". In addition to managing the process of information collection and dissemination, "1-800-HELP-4-ME" would create and maintain an interactive web based system – a public/ private partnership to link audiences, current services, services needed to address identified gaps and appropriate communication modalities. The system would be an informational resource to support and expand existing networks, and create new ones, while building on the efforts of others. The "1-800-HELP-4-ME entity's thrust will be dual:

- Undertake an awareness campaign that results in long term care issues becoming a part of the everyday consciousness of Fairfax residents;
- Develop a "life event" focused approach to providing information and connecting residents to existing resources (discussed in the following theme, "Connecting People to Services").

There are many examples of successful awareness campaigns in the United States and elsewhere that have achieved very high levels of issue awareness among the general population. Examples that come to mind are often about health (anti-smoking, anti-drug use, detection and prevention of various health conditions), safety (seat belts, use of helmets, designated driver, Miss Utility, crime prevention) or the environment (pollution, recycling and litter clean up). Many of these campaigns have succeeded in creating a very high level of awareness among the population about the content of the message ("Smoking is bad for your health", "Seat belts save lives"). The intent of the Task Force is to achieve similar levels of awareness among the residents of Fairfax about the key issues, realities, and concerns associated with long term care. This includes members of key industries and professions as well as the general public.

Objective 1: Develop and conduct a comprehensive and ongoing campaign that will result in long term care issues becoming a part of the everyday knowledge and awareness of Fairfax residents.

Overall Strategy: Initiate and maintain a process, sponsored by "1-800-HELP-4-ME", to create and disseminate information relevant to long term care for adults. This process will:

Strategy 1a: *Compile and maintain centralized sources of information related to long term care and assure that necessary information is available and readily accessible at an acceptable and affordable cost*. Many excellent sources of information on long term care services exist, but there is no central location for accessing them. As a result, consumers and caregivers have a "hit-or-miss" experience when they search for information. A central source of information would take advantage of the collected resources of the community.

Strategy 1b: *Develop and maintain a database of information available in various formats, languages and pictorials*. The Task Force found that while good information about long term care services does exist, it is often only available in English or in printed form, making it inaccessible for non-English speakers, individuals with impaired vision and those who are illiterate in their native language. Compiling resources in other languages and formats will aid consumers as well as providers, for whom multiple translations may be costly and difficult to produce.

Strategy 1c: *Create distribution channels through people and agencies which citizens frequently contact for such information*. The key to the success of the 1-800-HELP-4-ME campaign is that it builds on natural community networks already in place. Local and state agencies, health providers, non-profit and private care providers, as well as libraries, senior centers, and faith-based organizations are all part of the natural network for long term care communication. Using these outlets for communicating a clear message about long term care is an effective and efficient approach.

Strategy 1d: *Initiate and maintain a county-wide education program to inform residents about the coverages, costs, advantages and disadvantages of private long term care insurance*. Long term care insurance is one way of maintaining the financial flexibility to obtain the most appropriate type and level of care as an individual's needs change. The Task Force found significant information gaps about long term care policies; many believe that it only provides nursing-home coverage, while most plans also provide options for many other benefits such as assisted living, home care, respite care for the insured's care-giving spouse and even informal care-giving training. While private long term care insurance is available, it has not been widely purchased, the comprehensiveness of coverage varies significantly among policies, and the cost can be prohibitive for persons with limited income. While the number of employers who offer long term care insurance is growing, it is not yet a common component of most employer-sponsored benefit

packages. Outreach and education to Fairfax residents to enable them to ask for this type of coverage could be combined with outreach to employers to encourage them to offer it.

Strategy 1e: *Establish and maintain a county-wide education program to inform Fairfax residents about what is and what is not covered by federal and state programs such as Medicaid, Medicare, and Veterans Benefits.* The eligibility requirements and coverage limits for these federal and state programs are complex and change frequently. The Task Force found that many people mistakenly assume that Medicare or Medicaid will pay for the services they or their loved ones may need, only to find too late that their options for care are extremely limited or prohibitively expensive. Other than for persons in nursing facilities, recipients of auxiliary grants, and for the small number of persons with waivers, Medicaid coverage is not available as a comprehensive source of insurance coverage for low-income persons. Further, Virginia's waiver programs are often compromised by sudden changes in policies and procedures. While Medicare provides coverage for the older population, it does not provide coverage in key areas, such as prescription drugs, extended nursing home stays, and some health services provided in the home.

Strategy 1f: ***Educate the public about environmental supports that promote independence.*** While the principles of universal design are becoming more accepted in the building and product design industries, consumer demand will likely be the most important factor in bringing these designs to the marketplace. However, most consumers are not aware of the design options that could be made available to them. This strategy would educate the public about supportive designs for transportation and housing, as well as other environment support technologies. For example, a partnership could be developed with a local builder to showcase a universal design "Smart House," and/or a mobile "Smart House" could be equipped to travel around the Community for demonstration of adaptation options.

Strategy 1g: *Maximize the use of technology resources for the development and promotion of long term care educational materials.* Telecommunications and internet technology can bring information and services directly to the neighborhoods, shopping malls, homes, and even bedsides of consumers of long term care. This strategy would capitalize on utilizing existing methods of communication, such as E-Government Channels, Kiosks, interactive voice response (IVR) systems, Web sites and Cable TV. Fairfax has committed to expanding its use of E-Government to bring services directly to residents of the County. Long term care services and information could provide a wide-reaching application for this technology.

Strategy 1h: *Develop and implement an ongoing educational program for members of the long term care support system as part of the overall awareness campaign.* Consumers (and potential consumers) of long term care services are likely to turn first to their primary caregivers for information about long term care services and community options. Too often, those on the front line of communication – caregivers, clergy, physicians – are not equipped with accurate, up-to-date, or complete information. A targeted educational program should be part of the general awareness campaign to put reliable information in the hands of those most likely to be asked for it. Training sessions could be tailored for specific groups to account for the differences in format and content that might be required (e.g., physicians, clergy, and home health aides may have different needs)

Theme #2: Connecting People to Services

The Task Force found that there are many sources of information, education, training and advice about long term care services. The advent of Internet technology has made many of these sources more readily available to Fairfax residents than in the past. The Task Force found, however, that none of these sources provide the comprehensive scope that life events often require. For example, a caregiver with a spouse who has Alzheimer's Disease may need:

- specific information about home care services, adult day care and respite services.
- a support group to help with coping strategies.
- training to manage the behaviors of an Alzheimer's patient.
- a physician with expertise in treating Alzheimer's Disease.
- education about the progress of the disease.
- training on managing his/her spouse's activities of daily living without jeopardizing their own health.
- advice about how to modify the home environment to maximize the recognition and functioning level of the patient.
- legal advice about wills, living wills and powers of attorney.
- information about assisted living facilities and nursing facilities in order to do advance planning.
- a case manager to help coordinate the situation.

Each of the above can be found by an energetic person who has both time and self – navigating skills. But even that person's likelihood of success is much greater if they already have a general idea of where to start their search; a good idea of the full range of services they might need; if they speak and understand spoken and written English; are comfortable telling personal details to strangers over the phone; know how to use a computer; and are aware of the legal and financial implications of their situation. Relatively few people meet all the above criteria, especially when they are in the midst of a health crisis or major life event. To ensure that all residents can access the full range of needed services and information, the Task Force adopts the following goal:

GOAL: ENSURE THAT ELDERLY PERSONS, PERSONS WITH DISABILITIES, AND THEIR CAREGIVERS ARE CONNECTED TO INFORMATION AND SERVICES THAT THEY NEED, WHEN THEY NEED THEM, AT A LEVEL OF INTENSITY APPROPRIATE TO THEIR SITUATION.

Overall Strategy: The overall strategy is to improve access to services by undertaking networking efforts, improving eligibility processes, and connecting people to services. There are five key objectives to this overall strategy:

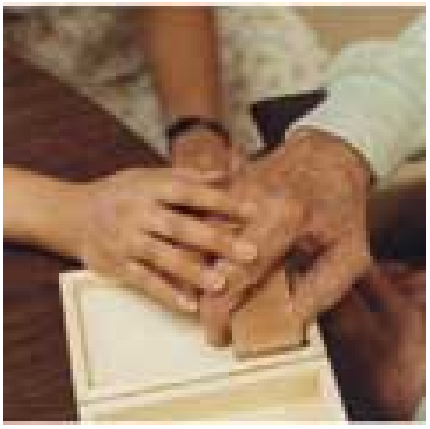
- Ensure that residents know where to begin their search for information and services.

- Ensure that residents can find information and assistance with the full range of long term care and supportive services they may need.
- Improve access to information and services for all residents, regardless of language or culture.
- Facilitate computer-literacy among consumers so that residents can use technology to access services.
- Raise the general level of awareness and knowledge of long term care issues and services so that residents are better prepared to manage life events.

Objective 1: Increase awareness of Fairfax's long term care services for the elderly and people with disabilities.

Strategy 1a: *Fairfax should position itself as a clearinghouse for information on long term care services and should use emerging technologies, such as linking to the SeniorNavigator search engine.* Fairfax already has the role of providing information and services for many long term care options, and the Task Force recommends that Fairfax builds on this role to become a central clearinghouse. Because people seeking help may not know where to begin, efforts are needed so that residents know where to start their search, and to ensure that many starting points for a search will deliver them to the clearinghouse. Linking to commonly used search engines and long term care-related sites will help ensure that residents find the assistance and services.

Objective 2: Integrate the delivery of a range of services essential to address growing gaps in unmet medical needs and ancillary services that are critical to community-based care.



Life events typically result in a range of service needs that cross disciplines and provider boundaries, and consumers are unlikely to have a clear picture of the full range of supports they may need. But there is no single source that is organized to provide assistance, linkages, or guidance on the full spectrum of supports. The problem is not that current resources are not doing their job. Rather, it is that no one organization is organized around all of the presenting problems associated with a life event. This structural problem results in multiple and varying eligibility processes for consumers, a fragmented approach to identifying and responding to service gaps, inconsistent linkages to faith groups and community-based service providers, lack of a coordinated publicity strategy for services, and insufficient linkage of ancillary services, such as transportation. The following strategies address these needs.

Strategy 2a: *Promote the development of a coordinated information system for one-stop eligibility determination, including the use of a uniform eligibility application.* The vast majority of long term care and supportive services have some form of eligibility requirement, either to determine that a consumer meets the financial, health, or demographic requirements to receive a service, or to determine the fee that will be charged for the service. With few exceptions, these are separate processes that may require a family to complete dozens of forms with the same information. There are opportunities for providers to use a commonly accepted application form, and to explore cross-program eligibility for certain services (i.e., if you are found eligible for one service, then you are automatically deemed eligible for another).

Strategy 2b: *Encourage and promote partnerships to address the growing gaps in unmet medical needs and ancillary services*. Partnerships between Fairfax and such organizations as Inova, Reston Hospital, George Mason University School of Nursing, Northern Virginia Community College, American Red Cross and others are a key strategy for linking the identification of a service gap with a comprehensive means of filling it. Too often, when a service provider does not have the technology, expertise, or means to meet the medical or ancillary needs of its clients with in-house resources, providers reach out on a case-by-case basis to fill the gaps. Establishing partnerships between major provider organizations would enable each to complement the others' strengths and provide more comprehensive care, without having to reinvent the wheel for each client. Such partnerships would also provide better information on system-wide service gaps and resources.

Strategy 2c: *Partner with faith community organizations that provide activities such as health education, in-home services and health screening programs.* Many faith-based organizations have responded to the needs of their members and communities by offering health-related services and supports. The Task Force recommends utilizing and working with the resources of the Fairfax Interfaith Liaison Office to access these existing services, to share information on services that are needed, and to promote the creation of additional service capacity.

Strategy 2d: *Increase awareness of long term care support groups through improved publicity venues such as the Golden Gazette, the Journal newspapers, and cable television*. Several studies have confirmed the emotional and physical toll of care-giving, and have found that caregivers often feel a sense of isolation. While there are long term care support groups offered in the community, many caregivers are not aware of them. The Task Force recommends partnering with Volunteer Fairfax to assist in developing and implementing improved publicity for support groups in a variety of media.

Strategy 2e: *Improve access to transportation services*. While the Task Force found a myriad of gaps in transportation services, the recommended strategies focus on improving access to all consumers, regardless of English-proficiency or degree of impairment, and on ensuring that the needs of long term care consumers are represented in local transportation planning.

Strategy 2e.1: Equip fixed-route vehicles with the capability to inform users of the vehicle location and route in a format accessible to the hearing and visually impaired and residents with limited English proficiency.

Strategy 2e.2: Ensure that consumers utilizing long term care services are represented on the Northern Virginia Transportation Commission to promote awareness of the needs of the elderly and persons with disabilities.

Strategy 2f: Increase availability of low cost dental services.

The Task Force found significant gaps in the affordability and availability of dental services for older adults and persons with disabilities. The cost of care at existing clinics is not affordable for many persons, even at greatly reduced fees, and clinics have waiting lists up to six months for services.

Strategy 2f.1: Expand the Northern Virginia Dental Clinic by facilitating the development of two additional sites, one in the South County area and one in western Fairfax County.

Strategy 2f.2: Initiate or support state legislation to expand Medicaid coverage to include dental care for adults. The County could introduce or support legislation that would provide access to low cost dental services.

Strategy 2f.3: Establish a program with local community colleges to provide site-based services in Dental Hygiene.

Objective 3: Improve access to long term care services in Fairfax for elderly persons and adults with disabilities of diverse cultures and/or with limited English proficiency.

Given the rich diversity of the Fairfax community, people seeking help may not speak English well, or at all. Recent surveys report that almost 30% of Fairfax households speak a language other than English in their homes. For an issue as complex as long term care, it is critical to reach and serve consumers in their native language. Further, there are cultural considerations for some persons related to seeking help, so there must also be an ability to serve in culturally appropriate ways.

Strategy 3a: *Identify operational models of service that may be replicated for use in Fairfax.* While Fairfax 's diversity presents challenges in providing culturally appropriate services, it also provides a wealth of cultural resources and volunteers to guide service delivery. Many cultural and faith-based organizations provide appropriate services to their communities, and could provide training and guidance to other providers in serving consumers from other cultures. For example, the Korean Central Presbyterian Church's Senior Center Program served over 200 seniors two days a week entirely with volunteers.

Strategy 3b: *Provide support resources to improve access to long term care to elderly persons and adults with disabilities in appropriate languages* (according to Federal Guidelines if Federal funding is utilized in this project). The Fairfax County Health Department is currently engaged in the process of ensuring that all necessary patient information is available in the five most frequently encountered foreign languages; Spanish, Korean, Vietnamese, Urdu and Farsi.

Objective 4: Facilitate the enhancement of elderly persons' and persons with disabilities' skill in the use of technology in order to access services.

Strategy 4a: *Expand outreach to seniors and persons with disabilities by providing educational opportunities regarding the use of computers through schools, libraries, businesses, religious organizations, teens, and/or recent retirees.* The Internet is an excellent tool to help residents find information and services (see the "1-800-HELP-4-ME" strategy in Theme #1: Public Awareness), but only if people know how to log on and navigate the web. Although Internet technology is approaching saturation levels in County households, potential consumers of long term care may not be comfortable navigating the Internet or even using a computer, or they may need adaptive technology to aid their use. Many schools have talented students looking for community service opportunities, and libraries provide free computer access in most communities.

Strategy 4b: *Encourage corporate representatives to assist with managing this process.* Many technology-savvy companies want to provide their employees with a way to contribute to their communities. Partnering with local businesses and schools to link volunteers with residents who need computer orientation could be a low-cost, high-impact strategy for meeting this need.

Objective 5: Provide consumers and families with the knowledge they need regarding long term care issues.

Many families do not begin to explore long term care until they are in the midst of a health crisis or other life event. The array of services and options can be overwhelming at the best of times, and even more so when time, health, and financial constraints are pressing. This objective underscores the need for the strategies in Theme 1: Public Awareness, to ensure that all residents of Fairfax have a general awareness and understanding of long term care issues and options.

Strategy 5a: Provide information about education and training resources available as part of "1-800-HELP-4-ME".

Strategy 5b: Develop and offer needed education and training to communities through identified active local neighborhood groups.

Theme #3: Promoting Independent, Supportive Living

According to the 2000 Fairfax-Falls Church Community Assessment, an estimated 10.4% of the Fairfax County population (104,818 persons) were either 65 years and over or an adult under 65 with disabilities. In 2010, it is estimated that there will be 187,378 persons in this group, representing 16.8% of the County's population, for a 78% increase over the ten year period. As more frail elderly persons and persons with severe disabilities choose to remain in their homes and communities, it is imperative that we find strategies for enabling and supporting independent living if our community is to avoid a crisis of care.

These demographic and social trends will present new challenges over the next decade. Services in the community (such as adult day care and other programs supporting persons who are frail or who have disabilities) will be in much greater demand. The kinds of issues that currently arise regarding location, financing, licensing, staffing and operation of child day care programs will become commonplace for programs serving persons who are elderly or who have disabilities. The demand for services provided in the home has already exceeded the supply of home care providers, and concerns about quality, affordability, and availability will continue to grow. Creating the capacity in the community to match the demand for services will be a significant challenge.

Other types of concerns, such as traffic safety, affect the entire population, not just those families directly affected by age or disability. The auto fatality rate increases for persons over 75, and rises steeply for persons over 80. With the dependency on the automobile as the primary means of transportation in this area, an increased number of automobile accidents involving older drivers is likely. Further, since older persons are over-represented in pedestrian fatalities (in 2000 persons over 70 accounted for 17% of pedestrian fatalities, but only 9% of the population) additional challenges will arise for pedestrian safety.

In the 2000 Community Assessment, approximately 25.6% of the population 65 and over (20,940 persons) reported a disability; 3.6% of the population ages 35-64 (21,730 persons) reported a disability. As the population increases overall and as the proportion of older persons in the population increases, the total number of persons with disabilities will increase. Since few dwellings in Fairfax were built to accommodate persons with disabilities, the challenge of adapting and modifying homes so that residents can remain in them will be significant.

The following thirteen objectives are grouped into four areas:

- Promoting Independence in the Community
- Promoting Independence at Home
- Promoting Access to the Community
- Promote Quality Environments for Persons Needing Assistance with Daily Living

GOAL: FAIRFAX COUNTY, FALLS CHURCH CITY, AND FAIRFAX CITY RESIDENTS WHO ARE ELDERLY OR WHO HAVE DISABILITIES WILL LIVE AS INDEPENDENTLY AS POSSIBLE

Promoting Independence in the Community

Objective 1: Increase and strengthen the availability, accessibility, and variety of community-based long term care options in response to the needs of people with disabilities.

Space, staffing, and program offerings limit current options for daily care and activities. For adult day care alone, 1063 persons age 65 or older reported using adult day care services in the 2000 Community Assessment. However, over 1880 persons age 65 or older reported not using the service, but needing it. In addition to excess demand, current programs are also struggling to provide the higher level of care and supervision that many clients require. More options along the continuum of care are needed to respond more appropriately to different levels of support required by adults. Community-based options that need strengthening or expanding include adult day care, social day programs to transition adults who need more intense services than a Senior Center or Club can provide, mental health counseling and employment services. Innovative options to explore include expanding the role of Senior Centers to be a service hub for seniors, and testing the model of family day care for adults.

Strategy 1a: *Establish more adult day care centers in local communities, including western Fairfax County*. *Partner with assisted living facilities, Inova Health System, corporations, and non-profits. Establish a stakeholders' advisory group to assess the need for adult day care centers and develop a plan to meet these needs.* Western Fairfax County has experienced rapid population growth in the last few years without a corresponding rise in service options available in the community. Community participation in planning and developing the centers is critical to maximizing the use of existing community resources.

Strategy 1b: *Provide a community based social day program that offers transitional services from senior centers to adult day health care. Evaluate the new pilot program in Reston "Senior Plus" and expand on this concept if it is determined to meet an unmet need in the community.* Historically, senior center programs have not been designed to serve the very frail or persons requiring extensive monitoring or support services. More and more, however, senior centers, as a result of demand and lack of alternatives, are being asked to serve a more frail population and those requiring

more extensive monitoring. A social day program such as “Senior Plus” could fill the gap between Senior Centers and Adult Day Health Care.

Strategy 1c: *Design and implement geriatric mental health and alcohol and drug treatment day programs*. A partnership between senior centers and mental health services and local universities could be designed to meet this gap.

Strategy 1d: *Expand existing mental health ongoing assessment and treatment services for adults 18 and over who are unable to come to mental health clinics due to their disabilities.* These efforts should include those who are medically fragile and homebound, and non-English speaking mentally ill adults.

Strategy 1e: *Expand community integration services for those patients being de-institutionalized as part of the closing of the geriatric programs in state mental hospitals*. Included in this is the provision of support services to nursing homes being asked to accept de-institutionalized and other seriously mentally ill older adults with medical and behavioral problems.

Strategy 1f: *Expand acute and permanent specialized geriatric residential placements for seriously mentally ill older adults.*

Strategy 1g: *Expand consultation, psycho-educational programming and support services for caregivers.* This would assist in preventing mental health disorders related to the stress of care-giving.

Strategy 1h: *Expand senior centers to become community based service providers for the organization and delivery of services.* This would ensure a continuum of care and safe and accessible recreation and community services. This takes the above strategies a step further and places senior centers as focal points for the delivery of multiple services.

Strategy 1i: *Evaluate and develop different models of long term care provision*. Models that show promise for further research into their applicability for Fairfax County include PACE (Program for the All Inclusive Care of the Elderly), the Care Coordination model, the long term care HMO, regional provider organizations, and the virtual organization.

Strategy 1j: *Establish a pilot employment project at a corporate cluster site. Involve corporations as sponsors where there is sufficient density to support a program.* This strategy is a potential win-win for both employers and employees. This could represent an attractive benefit for employees and a good employee retention and performance strategy for employers.

Strategy 1k: *Develop a public/private partnership to initiate an opportunity for younger persons with significant disabilities to participate in a workday program, at a corporate site.* The program should be designed to support individuals

therapeutically and integrate them professionally and socially in the corporate environment. Having the opportunity to make a meaningful contribution is a strong motivator and a highly rewarding experience for young people of all ability levels, and a key component of being a member of a community.

Strategy 1l: *Perform a needs assessment for non-institutional day care; i.e., individual families who provide day care for a small number of seniors. Establish standards of care for this service, similar to the standards that exist in the provision of day care for children.* Family day care is an innovative approach that is largely untested in Fairfax County, but could be a viable approach to enabling residents to remain in their neighborhoods and communities.

Strategy 1m*: Develop a regional short-term transitional housing center, an emergency shelter facility for clients with higher needs.*

Objective 2: Increase the availability of support coordination/case management for the elderly and persons with disabilities as needed.

Case management services are a set of activities that include outreach, service entry, assessment, service planning, arranging/linking, and monitoring that are designed to help an individual receive appropriate services in an effective and efficient manner. These umbrella activities can be delivered in the public, private, and nonprofit sectors. Individuals and families often (willingly or out of necessity) perform these roles for themselves or for their loved ones. There are several models of case management. Some providers serve primarily as information brokers and coordinators of services between providers. Other providers of case management function as authorizers of service. They are actually empowered to arrange, enroll, and start services. They can provide a "one-stop-shopping" feel to meeting a set of services needs. The County's Care Network for Seniors is an example of the "service authorization" model of case management services.

Strategy 2a: *Support the development of Faith-Based Initiatives and parish nursing programs in the community.* This is an idea that has had considerable success in rural areas where health resources are scarce. Parish nurses provide health screenings, education, and even case management services for the members of a faith community. This effort could be coordinated with the County's Interfaith Liaison Office.

Strategy 2b: *Build on what the County has learned from the current case management pilot program of shared case management between the Health Department and the Department of Family Services in Falls Church.* The County's long term care providers in Region II recognized the potential overlap in needs and services of Health Department and Family Services clients. Nurses and social workers are piloting a model of shared case management and supervision to streamline the provision of case management services to clients.

Strategy 2c: *Explore options for Case Management/support coordination to include peer-based and individually selected case managers.* Not every person needing long term care services needs intensive or professional case management. This strategy recognizes that many consumers of long term care and the people in their personal support networks are highly knowledgeable about the system and capable of serving as an advocate and advisor to peers.

Objective 3: Ensure adequate nutrition in the community.

A variety of existing programs provide food and nutrition services to older adults in Fairfax County, but the scope and availability of these programs is severely limited for younger persons with disabilities. The Task Force noted a number of gaps in availability and acceptability for nutrition.

Strategy 3a: *Expand food and nutrition programs by providing nutrition information services; increasing accessibility of food stamps and food pantries to targeted at-risk groups; and increasing the total number of congregate meal sites.*

Promoting Independence at Home

Objective 4: Enhance, develop and coordinate supportive services for the home for persons with disabilities so they may have productive and fulfilling lives and maximize to the greatest extent possible home ownership.

For most older adults and person with disabilities, remaining in one's own home near family, friends, and familiar places is the ideal living arrangement. Availability of the necessary in-home supports is often the factor that determines whether a person remains at home or must move to a more restrictive setting. Supports range from personal assistance services to respite for family members, and usually include some forms of assistive and adaptive technology, such as durable medical equipment, communication devices, or environmental controls. The Task Force found gaps in availability and affordability for many in-home supports. They recommend the following strategies for addressing those gaps.

Strategy 4a: *Initiate a public/private pilot project utilizing innovative technology in a specified geographic/housing site for persons with disabilities who are socially isolated or confined to their homes.* This strategy would promote and emphasize the needs for consumer driven services, promote self-determination and advertise the need for an innovative family support system. A partnership with a local builder is one possibility for implementing this strategy, possibly in conjunction with the public awareness strategies in Theme 1: Increasing Awareness of Long Term Care Services.

Strategy 4b: *Expand the capacity of respite care programs. Partner with community agencies to develop non-traditional models, and expand access to existing programs for respite care.*

Strategy 4c: *Advance the use of technology to expand the availability of in home care.* Technology now permits nursing visits to be done from a remote location, conserving staff time and cost. The Task Force recommends pursuing this concept due to the severe shortage of nurses and the cost of home care visits for the consumer. An additional concept to pursue is electronic medication dispensing. Traditional low-tech approaches such as telephone reassurance programs are also effective.

Strategy 4d: *Develop a pilot to create an on-call, subscription-based service that would provide personal assistants for temporary replacement or emergency back up personal assistance*. A participant subscription funding pool could be established to retain trained providers. The service should be made available to those with Medicaid and to those without coverage. Cooperative agreements could be made with likely providers, to include the provision of training, including ESL. Standards of care should be developed for the service, including a mandate that the client's care plan is clear to the temporary provider.

Strategy 4e: *Build on the findings of current innovative efforts in telecommunication technology.* Verizon Foundation and Carlow International are collaborating with Fairfax to determine the feasibility for a network to link up seniors and people with disabilities with support services and resources. These findings should be used for strategic planning.

Public/Private Partnerships

Strategy 4f: *Develop an Assistive Technology Partnership with George Mason University to provide training for all service providers who work with persons with disabilities*.

Strategy 4g: *Work with providers such as Johnson and Johnson to increase medical equipment availability. Establish a virtual warehouse to advertise used equipment available at greatly reduced prices.*

Strategy 4h: *Develop consulting relationship with Johns Hopkins Volunteers for Medical Engineering for customization and fabrication for assistive technology for single family housing.*

Objective 5: Make assistance available and affordable for persons with disabilities through advocacy**.** The Board of Supervisors should initiate or support legislation in the Virginia General Assembly to accomplish the following strategies.

Strategy 5a: *Amend the Medicaid State Plan to include personal care as a covered service.*

Strategy 5b: *Include case management services under the Medicaid Waiver Program where appropriate.*

Strategy 5c: *Establish a prescription drug benefit program in Virginia*. Work with the Joint Commission on Health Care to determine the most feasible strategy. One possible model is the program recently passed by the Maryland General Assembly which will allow seniors on Medicare to purchase up to $1,000 in medications annually with a $10 co-pay.

Strategy 5d: *Reinstate the Medicaid waiver for assisted living facilities*.

Strategy 5e: *Expand Medicaid's definition of assistive technology to cover items like lifts, computers, and environmental modifications and controls.* This would make independent living and earning a living possible for many more persons with disabilities.

Strategy 5f: *Continue to seek implementation of the Medicaid Consumer Directed Elderly and/or Disabled Waiver.*

Strategy 5g: *Encourage the State to revise its definition of "Priority Population"*. This should include those persons living in the community with dementia who need mental health treatment for their symptoms of severe mental illness.

Objective 6: Modify homes to permit continued independence for residents.

Strategy 6a: *The Board of Supervisors and/or the Department of Housing and Community Development should increase retrofitting options for homes in the County that are owned by seniors (over 60 years) and individuals with disabilities.*

Reprioritize efforts for retrofitting older homes that are owned by seniors. Create public/private partnerships with non-profits to assist with retrofitting homes, especially for low-income individuals. Provide County assistance with design specifications and permits to retrofit older homes. Designate a staff person dedicated to workingwith individuals and contractors to facilitate the retrofitting process.

Strategy 6b: *Make home modification more affordable by lowering the tax burden.* Possible options include offering a tax credit or lowering the real estate assessed value for homes that have been retrofitted by seniors and/or persons with disabilities.

Strategy 6c: *Make maximum use of available funding sources such as Virginia's visitability tax credit, Virginia's Assistive Technology Loan Fund and the Department of Rehabilitative Services funds*. Look to banks and their assistive loan funds, the Veterans Association, insurance companies and long term care insurance, Farm Credit Administration, Department of Housing and Urban Development, and the U.S. Department of Agriculture for assistance in funding home modifications and/or adding assistive technology.

Promoting Access to the Community

Objective 7: Increase the supply of accessible housing.

While the strategies in Theme 1: Public Awareness seek to increase the general public's demand for more accessible housing, the following strategies specifically target the supply of accessible housing, using incentives, advocacy, and education.

Strategy 7a: *Ensure full enforcement of the Fair Housing Act of 1988 and section 504 requirements.* These require compliance with basic access standards for all newly built multi-family dwellings.

Strategy 7b: *Provide incentives for developers to build fully accessible or adaptable homes.* For example, builders who comply with this type of construction would get zoning preferences.

Strategy 7c: *Increase "visitability" for new homes.* Focus on a few essential elements that make homes visitable by persons with disabilities. Recruit advocacy organizations to work with builders. Seek legislation to increase the number of visitable homes.

Strategy 7d: *Develop a countywide education for developers, builders and other interested persons on the visitability concept and local ordinances that relate to this concept.*

Objective 8: Develop an integrated transportation system that meets the needs of the elderly and adults with disabilities that is safe, acceptable, available, accessible, and affordable.

Mobility is a critical issue in maintaining a level of independence, preventing isolation and permitting the elderly and persons with disabilities to continue to make contributions to the community. The Task Force's transportation committee found significant gaps in the public transportation and para-transit systems in Fairfax, both in the routes available to all riders and in the routes accessible for riders with special language or access needs. The strategies below focus on better integrating existing transportation resources to make routes more accessible, and on planning for and creating new options to fill the gaps which remain.

Strategy 8a: *Establish a monitoring/measuring system to determine the requirements for transportation services for the elderly and adults with disabilities within the County.*

Strategy 8b: *Establish a Transportation Coordination System with a central point of contact.* The system would be responsible for implementing changes, managing a multicultural transportation information response and distribution system, designing and implementing travel training and assisting in optimizing the day-to-day operations.

Strategy 8c: *Establish a cross-route transit system to make major areas within the County accessible and establish fixed routes that are accessible.*

Strategy 8d: *Expand the capacity of Fastran's Dial-a Ride program to accommodate the transportation needs of low-income adults accessing therapy services.*

Strategy 8e: *Fairfax should fully support and fund the Americans with Disabilities Act (ADA) and Fairfax's paratransit transportation system for seniors and people with disabilities.*

Objective 9: Improve driving and pedestrian transport environments.

A personal automobile is virtually a necessity for mobility in most of Fairfax, and there are few pedestrian-friendly environments. These factors present hardships for many residents, but especially for older adults and those with impaired mobility, vision, or hearing. The Task Force recommends that the following strategies be implemented to address the needs of drivers and pedestrians of all ages.

Strategy 9a: *Fully implement the US Access Board minimum standard for access for pedestrian rights of way.*

Strategy 9b: *Improve pedestrian access by eliminating or greatly reducing pedestrian obstacles, which inhibit traffic or pose an outright hazard.*

Strategy 9c: *Ensure that senior drivers and those with disabilities are considered when making traffic and roadway improvements.* Improve lighting, signage, and take elderly and persons with disabilities into account in the development process.

Objective 10: Improve the quality of transportation services provided to elderly persons and persons with disabilities.

Strategy 10a: *Establish a training program for transportation providers to include customer service, disability awareness, passenger assistance, dispatch, maintenance, and transit management.*

Strategy 10b: *Establish an outreach training program for consumers on the availability and use of fixed and paratransit services*.

Strategy 10c: *Make more and better use of technological advances to make the transportation system more responsive, efficient and effective.*

Promote Quality Environments for Persons Needing Assistance with Daily Living

Objective 11: Increase the quality and affordability of assisted living.

Assisted Living or Adult Care Residences offer housing and health-related services for individuals who need some assistance with activities of daily living (ADLs), but who do not require skilled nursing care. They also serve older people who need help with ADLs as a result of cognitive or physical impairment. The Task Force found significant affordability gaps for assisted living in Fairfax County.

Strategy 11a: ***Support the following recommendations made by the Fairfax County Adult Care Residences (ACR) Study Group in 1998.***

- *The County's zoning ordinance should be modified to recognize assisted living facilities as a distinct category.*

- *The County should support the expansion of the District Home's facilities to meet the needs of persons of all ages with physical and mental disabilities who require an assisted living facility's services and develop an assisted living facility in partnership with the private sector to serve the younger population who are indigent and require assistance with ADLs.*

- *Conduct a study to determine the needs and requirements of persons with dementia in assistant living facilities to evaluate whether changes are needed in state regulations to safely serve this population.*

- *Develop a region-wide strategy to assist consumers and medical professionals in choosing and working with an assisted living facility*.

- *Encourage initiatives to develop affordable assisted living facilities using federal funding (including HUD 811 and 236 funds).*

Objective 12: Increase the quality and affordability of skilled nursing facilities.

Nursing homes or rehabilitative facilities are designed for people who need continuous skilled nursing or supervision on a 24-hour basis or sub-acute, respite, or rehabilitative services. The Task Force found that significant improvements are needed in developing a coordinated, prompt, and effective response to cases of neglect and abuse of residents in long term care facilities. The Task Force also encouraged efforts to create a collaborative environment that fosters shared training, information, and best practices about local protocols and open lines of communication about any misunderstandings.

Strategy 12a: *Enhance the ability of families to monitor the quality of care their loved ones receive in nursing homes through training and education.*

Theme #4: Improving and Expanding the Long Term Care Workforce

The workforce crisis is already here. The Virginia Employment Commission (VEC) tracks 750 job titles. For occupations requiring a post-secondary education or extensive employee training, registered nurses are ranked as #1 on the list of occupations with the most job openings. Licensed practical nurses rank #4 on the same list. For occupations that require a high school diploma or less, nursing aides, orderlies, and attendants rank 12th on VEC's list of job openings. The VEC projects jobs within Nursing and Personal Care Facilities to grow 4.9% annually through 2008. Jobs in Home Health Care services are projected to grow 21.1% annually during the same span of time.

An acute shortage of nurses is already causing Washington area hospitals to recruit overseas. The average age of the nation's nurses is 45 years. As they retire, they are not being replaced in sufficient numbers. Only 9% -12% of the nation's nurses are under 30 years of age. The Maryland Department of Health and Hygiene estimates that there are only three nursing graduates entering the field for every eight that retire. The 1999 Nursing Executive Center Report states that between 1993 and 1996, enrollment in nursing diploma programs dropped 42% and enrollment in associate's degree programs dropped 11%. The same report estimates that between 1995 and 1998 enrollment in baccalaureate programs dropped 19% and enrollment in Masters programs dropped 4%. These figures, along with the aging of the existing nursing population and the aging of the population in general combine to predict a severe nursing shortage between 2008 and 2030.

In addition to nurses, there are serious concerns for a broad occupational group critical to the provision of long term care. Known by titles such as home health aide, nurse's aide, certified nursing assistant, resident assistant, and personal care assistant, this group provides the hands-on personal care that people need in nursing homes, assisted living facilities, or their own private homes.

The median hourly wage of paraprofessional health care providers is $8.71 per hour – working an average of 29.6 hours a week. Total annual earnings under $13,000, with monthly incomes around $1,030, no health benefits or reimbursement for travel to and from appointments, result in extremely high turnover for workers in this field. Given the average monthly rent of $1,129 for housing (2 bedroom apt. rent as of Jan 2000) in Fairfax, the probability of an individual choosing home health care as their primary field of work is slim. Home health care occupations have one of the highest turnover rates due to low pay and status, poor benefits, low training requirements and high emotional demands of the work. Most home health aides work part-time on an on-call basis, have a second job, or live in a household where their income is supplemented by other members of that household.

There is also concern for a similar class of workers who provide residential, educational and vocational services to persons with disabilities. The term Direct Support Professionals (or DSPs) has been developed by the University of Minnesota's Institute on Community Integration to collectively represent workers who are known by such titles as residential counselor, personal care attendant, job coach, para-educator, program manager, or direct care provider.

In Fairfax's low unemployment economy (2.8% unemployment rate), attracting people to work in these jobs is extremely difficult. Retaining them is just as difficult. Yet these personal care workers are often the most critical staff when it comes to the quality of care provided to a population that is frequently in a vulnerable position due to frailty or disability.

The strategies recommended below are in no particular order and almost all require a significant investment of resources. Improving the long term care workforce will not come without cost, although this cost can be shared among the many partners who have a stake in the health of Fairfax's long term care system.

GOAL: IMPROVE RECRUITMENT, INCREASE RETENTION AND IMPROVE QUALITY IN THE LONG TERM CARE PROVIDER WORKFORCE

Overall Strategy: Develop a Consortium for public and private providers of long term care services to share ideas and strategies for recruiting and retaining workers. This Consortium should be independent from the County and be a self-supporting public-private partnership that would have as its mission the improvement of the long term care workforce.

A useful local model of this type of collaboration is the Nursing Assistant Institute (NAI), a collaborative effort of several local health, education and service organizations which was established in 1999 in the Charlottesville area to develop a trained and stable long term care workforce of direct care providers. The NAI is working to develop public-private partnerships with employers, nursing assistants, and other community members in the search for lasting solutions to long term care workforce issues. Already in place are: a calendar of advanced training sessions; a monthly meeting of a nursing assistant discussion group; a job bank and scholarship program; an annual Certified Nursing Assistant (CNA) Recognition Event; and a library of articles and texts related to Nursing Assistant issues. The NAI training model for CNAs is a multi-faceted collaborative approach with various stakeholders that could serve as a model for Fairfax in addressing similar issues. The proposed Consortium could operate in a similar manner to NAI and serve as a regional body that would coordinate and support efforts to address workforce and possibly other issues raised by the Long Term Care Task Force.

Objective 1: Provide incentives that improve recruitment and increase retention in the long term care provider workforce.

Strategy 1a: *Advocate for an increase in Medicaid and Medicaid waiver reimbursement specifically for the purpose of raising nursing, paraprofessional health care, and DSP salaries.* Medicaid finances 70% of the services provided in nursing facilities and a significant percentage of home health services. The Board of Supervisors should initiate or actively support legislation and/or budget amendments that would raise Medicaid reimbursement for the purpose of making nursing, paraprofessional health care, and DSP positions more attractive to prospective workers. Such a recommendation specific to CNA salaries was made by the Joint Commission on Health Care prior to the 2001 Virginia General Assembly session.

Strategy 1b: *Improve other compensation for nurses, paraprofessional health care workers, and DSPs.* Many other factors in addition to salary contribute to job satisfaction. Pilot programs should be put in place to test the effectiveness of improving job benefits on increasing recruitment, retention and job satisfaction. The consortium of providers (see Overall Strategy) could be used as a group purchaser of certain benefits (health insurance, life insurance, etc.).

There are a number of examples of programs that have attempted to address nurses', paraprofessional health care workers', and DSPs' job satisfaction separate from increasing their financial reimbursement. California's Caregivers Training Institute is a state-funded effort to improve nurse aides recruitment and retention, which provides supportive services such as childcare and transportation. Other state and provider programs have addressed general work skills, general education development, diploma preparation, or courses in English as a second language. Providing administrative leave for training opportunities is another idea that has received positive feedback when tried at the County's Adult Day Health Care program. Other recommendations suggest that simply having a basic benefits package (health insurance, sick and vacation leave) might be enough to increase job satisfaction of nurses.

Strategy 1c: *Establish competency-based training and provide experience-based educational opportunities for paraprofessional health care workers and DSPs.* These direct service providers, like nurses, need to have hands-on experience in order to learn patient care. Allowing nursing students to practice as CNAs while still in nursing school would provide an opportunity for such training.

A model competency-based training program has been developed by Sunrise Assisted Living, which has also established an assisted living concentration within the Health Science degree programs at George Mason University and Northern Virginia Community College. This program provides training for all aspects of assisted living, including administrators, nurses, and paraprofessional health care workers. Sunrise is offering guaranteed employment within its management training program to qualifying graduates of the Assisted Living Concentration at GMU.

Strategy 1d: *Develop a supervisory training program for long term care supervisors.* One reason for job dissatisfaction is inadequate management skills by supervisors.

It has been recommended that training supervisors in management skills would improve job conditions for long term care service providers and subsequently improve job satisfaction. Effectively implementing this strategy would involve the development of a certificate of Supervising Direct Care Workers in conjunction with local community colleges.

Strategy 1e: *Encourage long term care providers to involve caregivers in facility-level decision making*. This strategy is based on the idea that while top management should create quality of care through appropriate policy, decisions on how to implement the policy should be made by the front-line workers most familiar with the needs of residents. Having this type of role in facility-level decision making would increase a health care worker's or DSPs investment in their job and increase job satisfaction.

The Wellspring Program in Wisconsin is a collaborative effort involving 11 Nursing Home providers which has created "care resource teams" that receive specialized job training and are empowered to train other workers, develop, implement, and evaluate facility-level care and initiate structural changes. An evaluation of the Wellspring program showed that turnover rates for aides at participating facilities dropped from 110% in 1994 to 23% in 2001. The proposed Consortium (See Strategy 1) would be an ideal forum to test the effectiveness of such an approach in Fairfax.

Strategy 1f: *Establish pilot projects to develop career ladders.* Long term care providers argue that a career ladder is needed to provide some opportunity for advancement for care providers, and to offer enhanced salaries to those in the higher DSP positions. Career ladder development would require coordination with colleges and community colleges for the development of training. Establishment of a viable career ladder system may not be possible unless Medicaid and Medicaid Waiver reimbursement rates are raised, allowing for increased compensation for nurses who provide higher levels of care.

Fairfax has instituted such a career ladder for nursing assistants in the Adult Day Health Care Program, which has an excellent record of staff satisfaction and retention. The system establishes two levels of aides, Program Assistant and Senior Program Assistant, each with separate pay scales. The Senior Center Assistant positions are filled via a competitive process among Program Assistants who qualify via the acquisition of additional training. Preliminary feedback on this system has been very positive. A similar system should be established for home care workers, starting with the home care/chore aide workers and establishing a ladder that would end at providing assistance with medical technology such as gastric tubes. Such a ladder would establish some dignity for the workers at the beginning of the ladder as well as provide opportunities for advancement to more skilled work.

Strategy 1g: *Establish a system of voluntary accreditation, including staffing standards, for nursing facilities, assisted living facilities, and home health care providers.* Educate consumers about the associated standards. Overwork and being required to care for more clients than appropriate are often cited as reasons that nurses, CNAs, and other health care providers leave their positions. Such working conditions are usually stressful for the provider and may be dangerous to the clients.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed standards of care for both nursing facilities and home health care organizations that voluntarily choose to adhere to these standards. In Fairfax, the Consortium should encourage compliance with these voluntary standards of care and should initiate consumer education efforts to educate long term care consumers regarding JCAHO accreditation and its usefulness in making decisions about selecting facilities and agencies. Currently there are no such voluntary standards for assisted living facilities; the industry is, however, in the process of developing them.

Also, the Board of Supervisors should advocate for state-mandated and enforced staffing-to-resident/client ratios for nursing facilities, assisted living facilities, and home healthcare services, with appropriation of sufficient Medicaid and other funds for implementation of the staffing standards. Currently, neither federal nor Virginia regulations require a minimum staff-to-resident ratio or hours of care per day for nursing facilities. The Joint Commission on Health Care reports that, based on the results of several studies, Virginia's nurse staffing (includes CNAs) is comparable to that in other states. However, because Virginia's nursing facility residents have the highest acuity level in the nation, Virginia's nurses and CNAs have to provide a higher level of care to their residents than in other states.

Thirty-seven states have established minimum nurse staffing standards. State standards are varied and difficult to compare. As the Joint Commission on Health Care points out, while Virginia's *average* nurse staffing is comparable to other states, minimum standards would ensure that *all* facilities meet required staff levels.

Strategy 1h: *Paraprofessional health care workers and DSPs should utilize their professional association networks to advocate for improved wages, benefits and working conditions*. Nurses have successfully utilized the power of the national and local nursing associations to advocate for change. Long term care service providers should take advantage of their numbers by working together for systems change. The establishment of the National Alliance for Direct Support Professionals (see introduction) is a first step in making this strategy a reality for paraprofessional service providers. Nurses already have such structures in place, which can advocate for legislative changes advantageous to nurses.

Strategy 1i: *Facilitate long term care providers' transportation networks.* One of the largest obstacles to retaining long term care providers in Northern Virginia, especially for those providing home-based care, concerns the lack of an adequate public transportation system throughout the County. It is nearly impossible for paraprofessional health care workers and DSPs without their own transportation to reach certain areas in Fairfax County. Given the low wages paid to these employees, many of the paraprofessional health care workers and DSPs are unable to afford/purchase and maintain their own vehicles. In addition, even those with vehicles are not paid for their transportation time between visits.

One option is to take advantage of the Washington Region Access to Jobs Program, which provides transportation to and from work for nurses and paraprofessional health care workers and DSPs earning between 150% and 200% of poverty. For paraprofessional health care workers and DSPs making home care visits, this would mean rides to client's homes in hard-to-serve areas. The Fairfax Department of Family Services and Health Department are currently utilizing this program for home health care workers who work full or half-days at a single location. It may also be possible during non-peak hours (10:00 AM -2:00 PM) to utilize FASTRAN (or CUE or Fairfax Connector) busses not in routine operation to transport paraprofessional health care workers and DSPs to home care visits. This system could be operated in the same manner as the "Maids on the Go"-type services, where a number of paraprofessional health care workers and DSPs are driven to a number of different appointments by a single vehicle and driver.

Objective 2: Implement measures to improve the Quality of the Long Term Care Workforce

Strategy 2a: *Promote health careers and training options.* The Workforce Investment Act (WIA) of 1998 is a federal program designed to increase job training opportunities and improve the quality of the American workforce. Essentially the successor to the Job Training Partnership Act, the WIA creates State and local Workforce Investment Boards (WIBs) which are charged with determining the need for job training programs within their states. Virginia's State WIB is the Virginia Employment Commission. Fairfax's Workforce Investment area includes Loudoun and Prince William Counties, while Alexandria and Arlington constitute a separate area. Currently, the state Workforce Council does not contain a member representing the Health Care industry. The Northern Virginia WIB is in the process of applying for a grant from the Department of Labor to develop a training program offering skill development and upgrading for operations in the health care industry. If funded, the program would train 200 unemployed workers and 400 currently employed workers for a variety of health care jobs over a period of 24 months. The Board of Supervisors should advocate for health care industry representation on both the state and local WIBs. In addition, the Consortium of Long Term Care Providers should continue to work with these Boards to create training opportunities in long term care services.

Strategy 2b: *Develop incentives to get initial training as a long term care paraprofessional health care worker or DSP.* Incentives could include childcare, ESL classes, public/private scholarships, sites accessible to transportation, sites in community or faith centers, or outreach to multicultural organizations.

Strategy 2c: *Improve recruitment and retention by universities and colleges of nursing students*. Strategy 1c and 1d above, regarding the Sunrise/GMU/NVCC partnership addresses this goal for students who are not yet working in the field as well as with the provision of continuing education opportunities for existing nurses/DSPs.

Strategy 2d: *Promote awareness of the need for qualified nurses/DSPs.* Use the "1-800-HELP-4-ME" public awareness function to make people aware of the growing market and opportunities for careers in case management.